

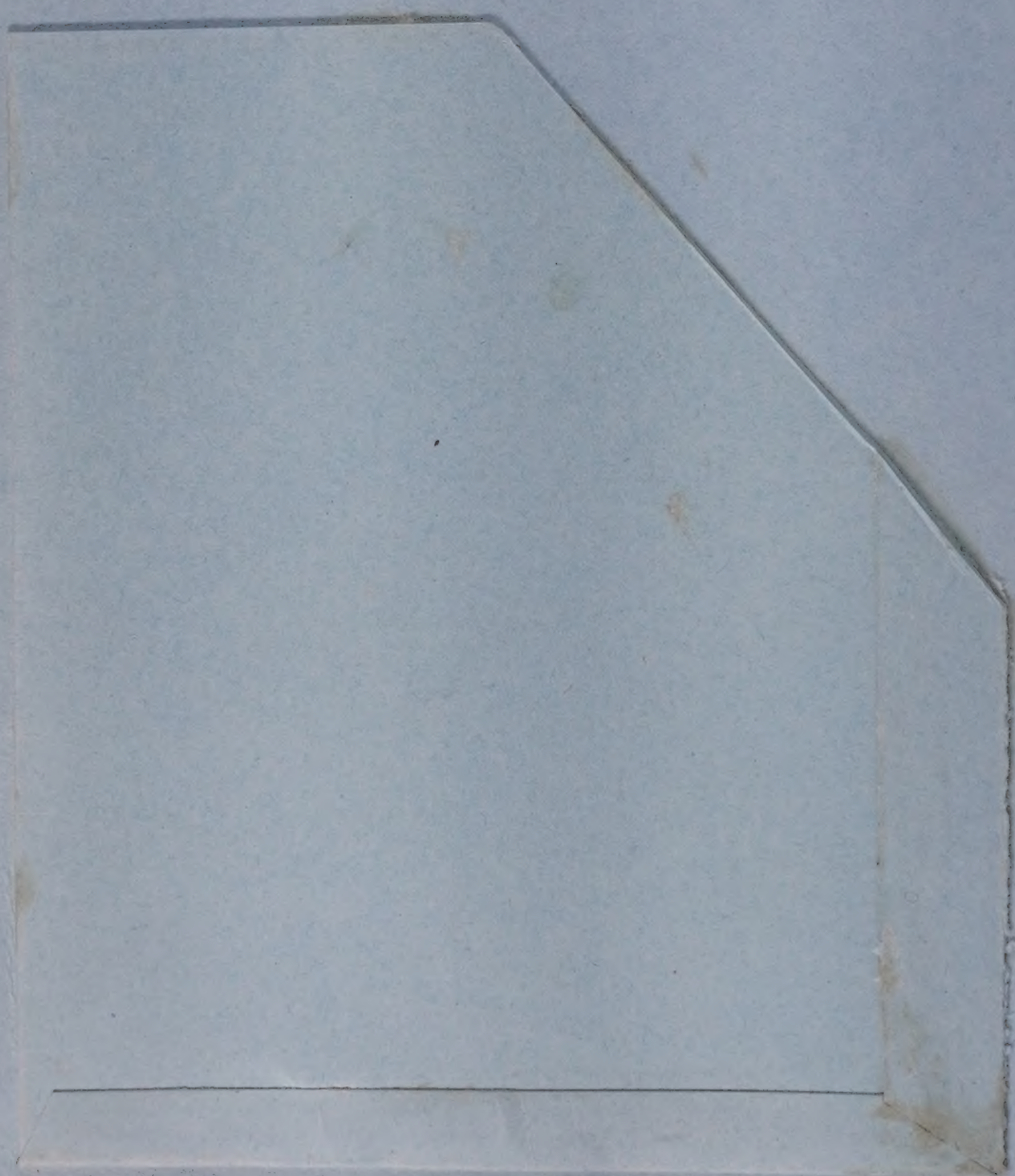
HOT SURGERY



CECIL G. CUTTING



02290



HOT SURGERY

THE term 'Cold Surgery' means an operation, or surgical procedure, which has been deliberately planned, and which is carried out after full investigation and due preparation, and at a time which is most advantageous to the patient. In rural India much of the surgery that we are called upon to perform must be carried out in circumstances and in conditions which are the reverse of all that is involved in 'Cold Surgery', and so may not inappropriately be termed 'Hot Surgery'. Actually, as will immediately be apparent to the reader, very little of the book has anything at all to do with surgery.

The book consists of a number of incidents and events collected together from memories of nearly thirty years spent in rural India. In some instances supplementary material has been added to draw out more fully the significance of incidents which in themselves may appear trivial. The main purpose of the book is to give some indication of the extent and variety of medical work carried out by Christian medical workers in India.

Many of the people referred to are still alive, and may be recognized by any who know them. But I hope that it will also be understood that in no instance is any disrespect intended, and that the recounting of the incidents is prompted by nothing but deep affection for India, the land of my birth, and its people—to whom I owe a debt of gratitude which I can never repay—gratitude for much friendship received. The incidents and some of the people may not seem very important, but I would recall a word spoke in private by Shri Jawaharlal Nehru—one of India's greatest patriots—and quoted by Earl Mountbatten : 'We are small men serving in a great cause, and in the process, some of the greatness falls upon us.'

C. C.

HOT SURGERY



Dr. Cutting makes a roadside stop

HOT SURGERY

CECIL G. CUTTING

C. S. I. Hospital
Chikballapur 562 101,
Karnataka, S. India.

First Published 1962

To Eleanor who shared in it all

Memorial Edition 1988

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Illustrations by Hazel Mickleburgh

Foreword to the First Edition by R. O. Latham

Foreword to the Memorial Edition by R. L. Robinson

FOREWORD TO THE MEMORIAL EDITION

This little book has long been out of print and not available. One copy remaining with us at Chikballapur was greatly appreciated by many short and long term visitors to Chikballapur. The author Dr. C. G. Cutting died in England on 20th February 1984, having spent 30 years in Chikballapur and a further 30 years in England after his "retirement", partly in general practice in the Brighton and Hove area. The C.S.I. Hospital, Chikballapur celebrated its 75th Anniversary in February 1988 and it was thought fitting to commemorate these two events with a new edition of Cecil Cutting's "Hot Surgery". There is a temptation to change the title to "Reheated Surgery" but the text is the original "Hot Surgery" and only some notes added as a postscript to tell something of the hospital as it continues to play its part in the life of the church in India in 1988.

This new edition comes with the approval of Mrs. Eleanor Cutting and her family and the agreement of the Council for World Mission the present successor of the heritage of the London Missionary Society, the original publishers of the book. Proceeds from the sale of the book will go towards the building of a new operating theatre complex at Chikballapur which will bear Dr. Cutting's name, as a memorial to his life and work in Chikballapur.

Dr. R. L. Robinson
Medical Superintendent,
C.S.I. Hospital, Chikballapur.

FOREWORD TO THE FIRST EDITION

I REMEMBER visiting a Hindu temple with Dr. Cecil Cutting and his wife. The priest in charge knew Dr. Cutting and readily agreed to our looking over his temple, and even to photographing the images of the gods. When we came out the priest asked Dr. Cutting to examine a baby which a woman was holding in her arms—this Dr. Cutting readily agreed to do, though the simple peasant woman was clearly bewildered. The priest spoke to her and said, 'You need not be afraid of Dr. Cutting, he is here in India in the name of his God to help the people of India.'

Throughout the district of Chikballapur, near Bangalore, where he worked from 1932 to 1960 he was known and trusted, and held in the highest regard; the people knew that he was there 'in the name of his God'. This district has been notoriously difficult to evangelize. There are over a thousand villages and only one or two churches, and these are weak and struggling. There has been no ready response to the Gospel. Dr. Cutting asked that for his last period of service he might be allowed to specialize in village evangelism, because he was always convinced that the need of the Gospel was even greater than the physical needs.

But this task of winning the villages of India for Christ is only beginning. Anyone reading this fine book of memoirs by an outstanding Christian doctor, will realize this. The work of Christ goes on and needs men and women as dedicated as Dr. and Mrs. Cutting are to carry on, and carry forward the work from which they have recently retired.

I commend this book for your reading, and these needy people for your prayers.

ROBERT O. LATHAM
Home Secretary
London Missionary Society

I

IT BEGAN IN THE CUSTOMS SHED

A few years ago, after a missionary meeting at which I had been speaking about India, a young man of about twenty years of age, who might have been expected to know better, came up to me and asked me quite seriously, 'Is there still much cannibalism about?' Cannibalism in India, my mind boggled at the idea. For a moment I was so stunned I hardly knew what to say; but when I had recovered a little, I replied, rather lamely, 'No! Most of the people are vegetarians.' No doubt there have been times and places when missionaries have landed on a coral strand or a sandy beach from an open boat with some trepidation, wondering what sort of a reception they were going to receive, and whether they would be met by a horde of halfnaked savages armed with clubs and spears. But today in most parts of Africa and Asia a missionary is more likely to disembark from a semi-luxury liner, and be confronted with a customs shed, and be met by a horde of officials and travel agents armed with printed schedules of tariffs and lists of landing regulations. I have sometimes wondered which reception was the more terrifying.

But all this is no indication that the day of the missionary is over. I was returning to India on one occasion and had with me a considerable number of surgical instruments. Now, all new instruments are subject to customs duty, and so are old ones if they are being carried for somebody else. I declared them as the regulations required. 'Are these the tools of your trade?' asked the officer. 'Yes', I replied, feeling much encouraged. But a more awkward question was to follow: 'Have you yourself used them?' I could not say that I had, at least not all of them; many of them were brand new. 'Well,' he said, 'let's separate the new ones from the old.' This was done. The officer was not at all hostile, indeed he was on my side. And as we inspected the gleaming new instruments he added, 'You're quite sure you've never used them?' Reluctantly I had

to admit that I had not. But he was still not quite done in his endeavour to be helpful. 'Haven't you even boiled them?' he asked. And again I had to say 'No'. 'Well,' he said, 'I'll get my boss and see what he says.' In due course the senior customs officers appeared, and we went over much the same ground as before. He, too, asked, 'You're quite sure you haven't boiled them, because otherwise I'm afraid you will have to pay a lot of duty on them.' There was really nothing more that I could add to what I had already said, so the senior officer turned to his subordinate. 'Make out the bill for the duty, and mark off all the rest of the baggage,' he said. When this had been done, and the duty paid, the customs man had one more question to ask: 'Would you mind if I consulted you for a moment?' he asked with some diffidence. 'What about?' I inquired. 'Well, about a little trouble I have. Shall we just go over there?' And he indicated a pile of packing cases. He came out from behind his barrier, and I accompanied him down the customs shed in the direction indicated. He sought some cover behind the barricade of packing cases, and there he divested himself of his trousers. The nature of his trouble was immediately apparent; the diagnosis was not in doubt; but his concern was to know what he should have done about it, 'I have been to a number of doctors,' he said. 'One advised one thing, and another, a very highly qualified consultant, suggested something different.' 'I would very much value your opinion, if you would tell me what I ought to do.'

Clearly, here was a man who was looking for a word that he felt he could trust, and I realized in a moment that my job as a medical missionary had already begun again, even before I had got out of the docks.

II

A SIMPLE ANSWER

It is generally recognized today that the success of a doctor in caring for his patients depends to a very great extent upon the confidence which they repose in him. It does not always depend, first and foremost, upon his learning, but upon his insight and upon his concern and sympathy. A dentist said to me the other day, 'You must share something of the feelings of your patient.' That's pretty good from a dentist, and it is true. Even so, one is sometimes a little shocked by the implicit trust that is placed in the word of a medical man. 'The doctor says I must take care of myself,' one often hears, as though it were the oracular utterance of a being who does not belong quite properly to this world, and as though most of us were not busily engaged most of our time in doing just that.

A cultured and very highly educated young man brought his small child to Chikballapur one day. He was obviously greatly concerned about the child, though it did not look very ill, and, indeed, was not very ill. From time to time the child developed a little fever; it was fretful, and would not take its food properly. A common enough state of affairs, you may say, and one which you may see in any country, but one which, very naturally, worries the child's parents. They are anxious about what it might mean; is it malaria? or is it infantile paralysis?

'I took the child to a doctor in our town,' he said, naming one of the leading practitioners there, 'but I was not satisfied, so I took the child to see the district medical officer.' He would be the most senior government doctor in the whole district. Evidently he had suggested something else. But this also did not seem to suit the case. 'I then brought the child up to Bangalore and showed it to Dr. S.,' the father continued. Bangalore is one of the largest cities in south India. It has several large hospitals and a medical college. The doctor he named was at that time one of the best known and most highly

respected doctors in the city. He had evidently examined the little patient carefully, and had prescribed a line of treatment. There had hardly been time to give this a fair trial before he came to Chikballapur. 'But you have already had all the best medical advice that is available,' I said. 'What more can you expect us to do in this country place that they are unable to do in a big city?' 'Tell me what I am to believe,' he said. 'But,' I objected, 'will you believe what I say? Why should you accept my word rather than that of the much more eminent men that you have already seen?' His answer was simple and unequivocal 'Ah, yes! but this is a Christian hospital.' It was an answer which ought to make any of us feel pretty humble, but, poor Christians that we know ourselves to be, it is right that people should expect from us something more than the ordinary.

III

WHY CHRISTIAN HOSPITALS ?

One day I was walking with a colleague through an Indian village market. A weekly market is held in many small towns or large villages, where people gather from neighbouring villages to sell their wares, and to get their modest supplies for the following week. In the evening you may see them returning to their own villages, trudging along the dusty road in the lengthening shadows, bearing with them the small purchases they have made — a new earthenware cooking-pot containing a few chillis and a handful of country vegetables for the curry, a bottle of oil for their lamps, a scrap of coarse cloth for a new shirt, a few measures of some grain done up in an old rag. A man may be dragging along a recalcitrant sheep that he has just acquired, or a couple of scraggy chickens suspended by their legs. The chickens look too tired and undernourished to care what happens to them. Behind the man, always behind and never in front of him, trudges his wife carrying a baby on her hip, and with one or more small children hanging on to her sari. Sometimes the man may carry one of the children on his shoulder. Often they look cheerful enough, and you might think that you were viewing a bucolic idyll, if you did not know that what you are looking at is a picture of grinding poverty.

A market is a good place for meeting people, and we were wondering whether this might not be a good place to start a weekly dispensary. Presently a man came up to me and asked me if I would go to his house to see his brother. 'Yes,' I said, 'go ahead,' and we followed him into the village. He was a farmer, and by no means a poor man, though you would hardly have guessed that from his appearance. His father owned some of the best fields in the neighbourhood. By the standards of rural India they were well off, and had influential connections. He told me that the District Commissioner (that is the senior government magistrate of the district) was a relative of his.

Indians seldom speak of a 'distant relative'; if he is a connection at all — however remote — he is 'near relative'. Another 'cousin-brother' (generally meaning a first cousin) was a doctor in the large teaching hospital in the city of Bangalore.

Their house wasn't much to look at; an old-fashioned village construction of mud and stone and rough-hewn timber, but rather larger than most. The door was large, as it had to be to allow cattle to pass in and out, but the house was almost devoid of windows; a hole in the roof permitted the escape of the smoke from the cooking; from a hole in the wall at ground level dirty water trickled, and then stagnated in a pool at the side of the street. I remember that as we went in, we were nearly knocked over by goats that were coming out; a number of chickens scattered in all directions. One or two buffaloes, a cow and some bullocks were tied along one wall. It is usual for cattle to share part of the dwelling house of their owner, as they may well be his most valued possession. A rough blanket was spread on the floor, and we were invited to sit on it. We had, of course, left our shoes outside the door, not because it was expected of us but as a gesture of courtesy and a mark of respect. In due course the patient was produced. He was a tall, cadaverous-looking man in early middle life — excessively thin, with a wrinkled face that belied his age. He wore a long shirt, made of some coarse dark material, which reached down towards his knees. This totally concealed an insignificant loin-cloth. He told me he had a pain just there, indicating an area that corresponded to about the middle of his shirt in front. 'I have been unable to take anything but milk and *conjee* (a sort of thin gruel) for five months,' he said. I had no difficulty in believing that. I got him to lie down on the blanket and proceeded to examine him. He was evidently suffering from one of those digestive ulcers that are as common in India as they are in the West. In the West it is fashionable to say the ulcers are due to the speed of life and the nervous tension and large responsibility which bear upon the highly placed executive. In the East we are content to think, they may be due to coarse

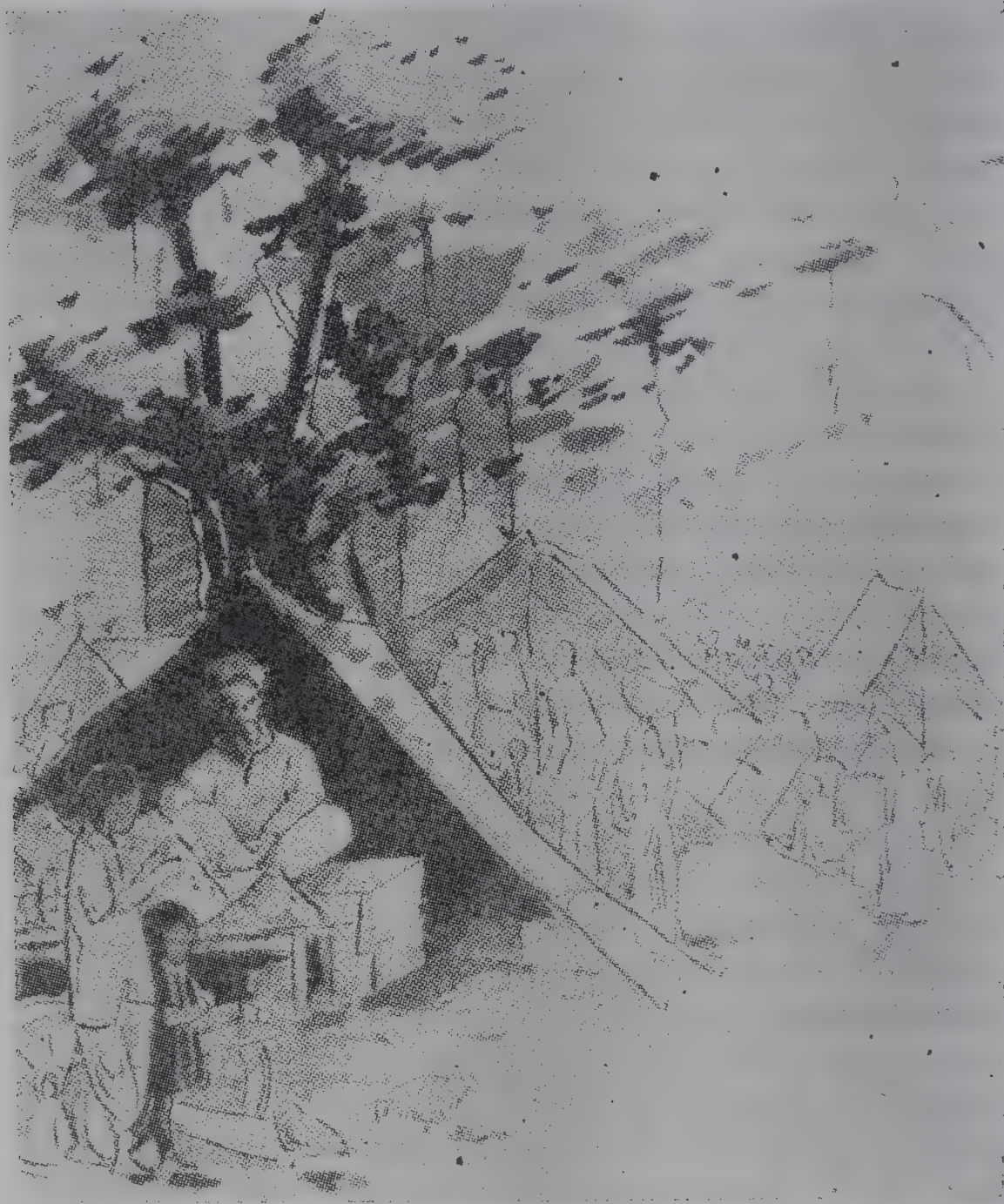
and excessively pungent food. I suggested to the man that he ought to go into hospital, where an X-ray examination could be made, and other tests carried out. 'An operation will probably give you a lot of relief,' I suggested. 'Why not go into Bangalore, where your doctor-cousin is, and see what he suggests? Or, if you like, come along to Chikballapur, which is only twelve miles from here. Anyway, think it over.' And with that we left him. About a week later he arrived at our hospital accompanied by a number of relatives and a great variety of baggage, which included bedding, cooking utensils and a generous store of provisions. We installed him in one of the private wards and lodged his relatives and part of the baggage in the adjacent kitchen.

When all the investigations had been completed, and the original provisional diagnosis had been confirmed, I again suggested to him that an operation would be the best line of treatment. He accepted this, and in due course the operation was done. About three weeks later he was ready to go home, and before he left hospital he gave us one hundred rupees — about eight pounds sterling. In those days that was a considerable sum of money for a village man. It was a time when the purchasing power of the rupee was about five times what it is today.

It is a simple story and could be paralleled over and over again in any mission hospital. Here was a village man, barely literate, but well endowed with the natural shrewdness of the peasant where his own interests were concerned; a man who was not without influential connections; he could have been treated in a large city hospital which could offer better amenities than our small country hospital; he could have been under the care of one of his own relatives; he might well have expected preferential consideration; and might have been treated free. But he sets aside all these advantages to be treated in a Christian hospital. Is it unreasonable to ask why this should be? I would suggest that the answer is that he expected to

HOT SURGERY

find there something a little out of the ordinary, something extra. I hope he found what he was seeking.



Village market

IV

A CLUE TO THE ANSWER

A few days ago I received a letter from an old friend in India. Indians are given to two things at least : offering generous hospitality, and making over-statements. I should be covered with confusion if the whole letter were published, but one sentence from it may be quoted. 'One thing causes us pain,' he wrote. 'It is that we were not fortunate enough to give food to both of you (that is my wife and myself) at least once in my poor villa.' Before leaving India we were under the necessity of declining all invitations to dinner, or I should not now be alive to tell the tale.

My friend has retired from service now, but when I first knew him he was a sub-inspector of police, and was attached to the railway department at the time. Twenty-five years ago he brought his small daughter to the hospital to have her tonsils removed. She herself has been married long since, and now has numerous children of her own. The operation, so far as I can remember, was straightforward, and the immediate convalescence uneventful. The day to go home arrived, and the father had brought the bus which was to take them to the railway station twenty miles distant, right into the hospital. Inspectors of police have great influence with bus drivers in India. Just as she was due to leave, the child had a brisk bleeding from the place where one of her tonsils had been. An event of this kind is naturally very disconcerting to everybody concerned. There was nothing for it but to put the child back to bed, attend to the bleeding, and send the bus away. This was done, and after a few more days in hospital she was able to go home.

A few weeks later I had to go down to Bellary for some committee meetings. As I stepped on to the platform at Bellary station, I nearly fell into the arms of my friend the sub-inspector. Immediately he asked me to go round to his house,

or at least to come that evening. I explained that I really could not come that evening, as I was only to be in Bellary for one night and my host would be expecting me to have dinner with him. 'Well,' he said, 'then you must come for food tomorrow.' Again I had to decline, and explained that I should not be free. 'What time will you be leaving?' he asked. 'By the afternoon train — about four o'clock,' I replied. 'Then I shall bring food to the train,' he announced. And with that we parted, and I proceeded on my business.

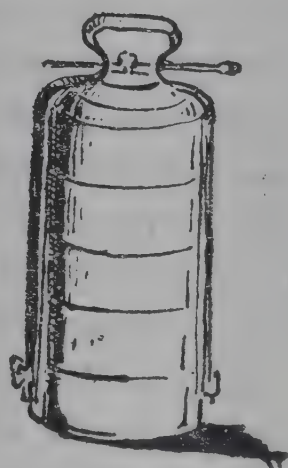
The following afternoon when I got to the train, as good as his word, there he was. He was accompanied by two police constables carrying a primus stove, cooking utensils, tiffin carriers and vast supplies of food. A tiffin carrier is a cylindrical affair composed of a series of circular brass vessels with flat bottoms, and they fit one on top of the other. The whole is held together by strips of brass at the sides, and these are attached to a handle at the top. Each separate vessel contains a different article of food. The largest one is at the bottom, and probably contains rice or *chapatis*— a sort of flat pancake made of coarse wheat flour. The remaining vessels may contain pepper water, curry, vegetables, chutney, milk curds or butter-milk. There could be a great many other dishes, but tiffin carriers usually do not run to more than half a dozen tiers.

From Bellary to Bangalore is an overnight journey by train, and we were travelling 'inter-class'. 'Inter' is the third of the four classes which were in vogue on the Indian railways in those days. 'Inter' being the second cheapest of the classes tended to be crowded. When the train came in, the constables immediately mounted it, armed with their various culinary impedimenta, and proceeded at once to make clear an ample space in the 'inter' class compartment so that they might have sufficient room to set up their cook-house. Eventually I got in accompanied by my host. As this was a section of the line for which he had constabulary responsibility he was not under the necessity of paying a fare, so decided to travel with me for

at least part of the journey. As we travelled the constables got on with the business of preparing the evening meal—warming up the *pilou* on the primus stove, and so on. (*Pilou* is essentially rice cooked in clarified butter and suitably seasoned.) In due course the meal was ready, and the *pilou* and other dishes were served on plates made of leaves stitched together. The leaf-plates were spread on the seats of the compartment. It was an entirely cordial occasion and quite free from any feeling of embarrassment.

As we had the whole night before us there was no need for undignified haste, and as we journeyed we talked. He told me a good deal about life and its difficulties in the police service; and then went on to speak with much appreciation of our hospital, and the treatment that he had received there. Presently he asked me, 'Do you remember the time when my daughter had that bleeding?' I assured him that it was something that I should not soon forget. 'Well', he said, 'I felt that those nurses were my friends. I believe they loved my daughter—they were actually weeping.'

I have never forgotten those words, and often I have thought about them. Indians, as I said, are given to making over-statements, just as the English are famous the world over for under-statements, but even when allowance has been made for this tendency to over-statement, there may still be something in what he said. I like to hope there is. It is that little extra, the more than ordinary that people are seeking.



Tiffin carrier

V

THOSE NURSES

'I FELT that those nurses were my friends. I believe they loved my daughter.' Words spoken, I believe, in sincerity and simplicity by a sub-inspector of police in a train as it rumbled slowly through the starry Indian night. One could wish that they were always true of the nursing profession in any country. Medical missions have done a great deal in India, as in most other parts of the world, during the last century, and it would be difficult to think of any field of medical work in which they have not given a lead. My own feeling is, that it is in the training of nurses that they have made their most outstanding contribution.

Fifty years ago, about the time when most of our London Mission hospitals in India were established (two are considerably older than that) there were practically no trained nurses in India, apart from those who came from abroad. Medical colleges had been founded by government much earlier, the two earliest in Calcutta and Madras, 1835. In Chikballapur the hospital was opened in February 1913, and the first Nursing Superintendent, Miss Isabella Scott, arrived towards the end of that year. No nurses were then available. Most of the functions of a nurse were carried out by a small group of young men, known as 'compounders'. They underwent a course of training which was a mixture of elementary dispensing and simple nursing. The idea that young educated girls should undergo training in nursing and be exposed to the free intercourse between people which life and work in a hospital entails was as unthinkable then as it had been in England half a century earlier. All the intimate personal service which nursing involves was regarded as menial and even degrading. Within a Hindu family the sick were cared for with the greatest devotion, and often at great personal risk to other members of the family, but the conception that you might have a responsibility beyond the family circle, and even more beyond your own caste, would

have sounded novel indeed. The only women who would offer to do such work were middle-aged widows who were practically illiterate. Most of them could not even tell the time by the clock. Teaching had to begin at the very beginning of everything, and could not be too elementary.

If you wanted any nurses, you had to train them yourself, and the training was something individual to the hospital. Co-operation between hospitals and standardization of training came later. The Christian Medical Association of India had a nurses' auxiliary, and in due course this Nurses' Auxiliary set up a 'Nurses' Examining Board'. The Examining Board started a three years course of training in nursing; prepared a syllabus; published a small textbook for nurses in India; had it translated into the widely used languages of south India; sent out teams of nurses to inspect the mission hospitals that were training nurses; and conducted examinations in the procedures of practical nursing. The Examination Board also issued certificates to those who completed their training and passed the prescribed examinations, and enrolled the names of the successful candidates in a register of trained nurses. So the foundations of an indigenous nursing profession were laid. At a later date, in 1916, when the Madras Nurses and Midwives Act was passed, and a State Register of nurses was established, all those nurses who held Indian Christian Medical Association certificates were admitted to the State Register. This practice continues to this day, though the initiative has largely passed out of the hands of the mission hospitals, and it is now necessary for our Christian hospitals to conform to the standards laid down by the India Nursing Council, and the various State Nursing Councils.

At the time that India won her independence, in 1947, and before partition of the country took place, it was estimated that there were seven thousand trained nurses in India, that is about one nurse to every 56,000 of the population. At the same date it was calculated that in Britain there was one nurse

to every 354 of the population. Therefore, to bring India into line with Great Britain at that time, not 7,000, but more than 770,000 nurses would have been required. So long as we look upon these figures only as an exercise in arithmetic, they may leave us pretty cold, but if we ourselves were numbered among the sick who stood in need of the care which only skilled nursing can give, we might feel very differently about them. Of this pathetically small number of nurses, the vast majority were Christians. At that time it was said that eighty per cent of the nurses in India were Christians, and that of these, ninety per cent had been trained in Christian hospitals. Why should this be? Three reasons at least may be given. The level of literacy among Christian girls was very much higher than among girls of any other community. (The Indian Nursing Council now requires that candidates for nursing training should at least have passed their secondary school leaving examination). Christianity gives to women a very much larger measure of social freedom than does any other religious system in India. Girls from non-Christian communities are generally married at a much earlier age than is the custom among Christians.

During the last ten years great changes have taken place, and much progress has been made. Educational and professional standards required of nurses have been raised; the total number of nurses in India has risen almost fourfold. But more is required of nurses than higher education and greater technical skill. Good nursing can hardly be learnt in a bad hospital, but only in a hospital where good nursing is habitually done. It is that 'something extra' that Christians ought to be able to offer, it is the touch of their Master.

VI

THE TOUCH OF CHRIST

CHIKBALLAPUR is a name which must frequently appear in these pages, but few readers will have any idea as to where it is, or what sort of a place it is. Chikballapur is a country market town with a population of about twenty thousand people. It is situated in the northeast corner of the old Mysore State. I say old Mysore State because, since the states of India have been reorganized, the State of Mysore extends far north of Chikballapur. It stands on a plateau three thousand feet above sea level. On its western side it is surrounded by a semicircle of rocky hills covered with rough scrubby jungle. The highest of these hills, Nandhidrug, sacred to the god Shiva, rises to a height of nearly two thousand feet above the surrounding plateau. There are a number of other peaks in the range which are nearly as high. Agriculture is the chief occupation of its people, and along with agriculture goes the rearing of silk worms. *Ragi*, a sort of millet, together with *cholum*, another kind of millet, groundnuts and beans are the principal field crops. Sugar cane and rice are grown on land which can be irrigated from tanks. Potatoes, onions, chillis, and other vegetables are grown in gardens. By the word garden is meant a sort of allotment which can be watered from a well. Potatoes and onions do well in the temperate climate, and it is on account of the potatoes and onions that the name Chikballapur is known from Calcutta to Colombo. When the first rains have clothed the fields in green, there can be few scenes more lovely. Fields and gardens stretch away from it on every hand; and not more than a mile distant, misty in the mornings, but clear against the sky at sunset, are the hills. It is claimed that among these hills all the rivers which fall into the Bay of Bengal between Nellore and Pondicheri take their rise.

It is an old town, founded some five hundred years ago by a local chieftain, Biregowda. It had its own small Rajas, who threw in their lot with the British against the French in the

Mysore was a hundred and seventy years ago. The relics of the ancient fort — roughly constructed earth works, brick-red in colour, and surrounded by a deep and wide moat — serve as a playground for goats and a hiding place for lizards. In the moat stand pools of greenish water which provide a breeding ground for mosquitoes. Just beyond the walls of the old fort, and outside the limits of the town proper, are the houses of the depressed class people. These depressed class people are now euphemistically called the 'earliest' or 'aboriginal' people, and are referred to in government documents as the 'scheduled castes'. Many years ago the mission established an elementary school in this area; and a number of families became Christians. Nobody would regard that school as a very ambitious adventure in the field of education, but at the time it was started it did offer some slight educational opportunity to many children who would have otherwise had none. I have heard it referred to as one of the best schools in Chikballapur. Certainly, through the years, a number of boys have passed through it who have since come to occupy positions of responsibility.

The hospital is situated on the outskirts of the town to the north, and stands in a large compound with many beautiful trees and flowering shrubs. Blue jacarandas, purple bauhinias, pink and scarlet poinsettias, varying shades of red and orange gul mohars, and an avenue of cork trees with their delicately scented white flowers perfuming the air, hibiscus of many shapes and colours give joy to staff and to patients. The thought of these makes us homesick for India. Only the temperate climate of Mysore makes it possible to grow such a variety of trees and flowers.

It is a general hospital — that is to say there are beds for men, women and children — and admits patients suffering from all sorts of conditions. We have one hundred and ten beds including children's cots, and ten of the beds are in a separate maternity unit. By Indian standards it is quite a sizable hospital, though much smaller, of course, than most of the



Poinsettias

hospitals in the cities. Twenty of the beds are in private wards each of which has its own separate kitchen, because most of the patients are accompanied by relatives who come to do their cooking for them. One can imagine the look of dismay, if not of defiance, on the face of a ward sister in an English hospital if she were confronted with a patient's '... sisters and his cousins and his aunts', not to mention a formidable grandmother who is accustomed to getting her own way. But they are not in England, nor are their customs the same as English customs; so why should we try to press our customs upon them? A man said to me one day, 'This isn't a hospital, this is our home.' No doubt it was intended as a compliment, and I accepted it as such. We most of us like to be at home when we are not feeling well. You could hardly imagine an Indian child in hospital without some relative to look after it; and very often it would be impossible for a woman to come to

hospital at all if her husband and children did not come with her. Circumstances of this kind are not without their difficulties and their disadvantages, especially when your objective is to train nurses. Sometimes the thing a patient needs most of all is to be separated from his relatives, but it is quite impossible to devise a single plan that will meet all circumstances.

Each year more than two thousand in-patients and well over thirty thousand out-patients are treated in the hospital, and a fairly wide range of general surgery is done. There is a small clinical laboratory, which is particularly important in a hospital treating many tropical diseases, malaria, for instance, and dysentery; and we also have a fairly efficient diagnostic X-ray department. The general equipment of the hospital is a great deal better than it used to be, though it still leaves much to be desired from every point of view, especially from a nursing point of view.

When the hospital is fully staffed, which, unhappily, is seldom the case, particularly as far as nurses are concerned, we have one missionary doctor and one missionary nurse; three Indian doctors, one of whom is a lady doctor, and twenty staff nurses. In recent years, owing to the shortage of nurses, we have had to employ a number of untrained staff; 'nursing orderlies' on the men's side of the hospital, and 'ward ayahs' on the women's side. Most of them are very willing, and do everything they can to help the trained nurses. It is not a very satisfactory arrangement. but even in America, we are told, 'nursing aids' and so called 'practical nurses' are finding their way into hospitals. Our total staff, including dispensers, laboratory and X-ray technicians, cooks, cleaners, sweepers, and washermen number sixty.

The hospital has been inspected on a number of occasions by nurses appointed by the Examining Board, and by the Madras Nurses' and Midwives' Council. On one occasion, no less a person than the nursing superintendent of the Madras General Hospital came to visit us. All of them have expressed

their appreciation of the work being done in our hospital, and have said that it is quite sufficient both in quality and variety for the training of nurses. The Mysore Government also has expressed its satisfaction in this respect. Indeed the Mysore Government makes a small grant-in-aid of thirty pounds a month (with no strings attached) to our hospital. That may not sound very much, but it is a mark of the Government's appreciation of our work, and it is quite as much as is given to any of the mission hospitals in the State. It amounts to approximately ten per cent of our monthly budget.

Thirty to forty years ago most of the mission hospitals in south India, apart from the purely women's hospitals, were training male nurses. Most of the larger hospitals, like the L.M.S. hospital at Neyyoor, trained both men and women nurses. At the time it was regarded more suitable that men should be nursed by male nurses. Male nurses are often very efficient in carrying out the technical procedures which modern medicine, and particularly surgery, requires. They can make very efficient operating-theatre nurses, but it is only the exceptional male who makes a good bedside nurse. It was unusual in India for either girls or boys who were brightest at school to go in for nursing. Girls who were good at school preferred to become teachers. In the Mysore State particularly it was difficult to get well-educated girls to take up nursing. Even so, the Chikballapur hospital was unique among the Christian hospitals in south India, in that for many years it trained male nurses only. Today the Government of India requires that every candidate for nursing should have passed his, or her, Secondary School Leaving Certificate (universally spoken of as the S.S.L.C.). This was not always the case, and we generally accepted boys for training who had appeared for the examination even though they had not passed it — provided they had a reasonable knowledge of English. But thirty years ago, we were glad enough to get boys who for various reasons, generally on account of poverty, had had to leave school two and three years before reaching that standard. Naturally those

boys who were brightest at school were best able to cope with the bookwork and study that a nurse must do; but it does not follow that they always made the best nurses. Nursing requires sympathy, an understanding of sick people, and a feeling for humanity.

So much then for the background; and now for the close-up. Nearly fifty years ago a boy was born in the depressed class quarter of Chikballapur. His mother was a very poor woman, and entirely illiterate. The home consisted of a single room which offered nothing in the way of comfort, and little enough protection from the heat of the sun, or from the heavy monsoon wind and rain. Within a few months of his birth, the baby's father died. The woman had to provide for herself and for her small son by going out to work in the fields. For a whole day's toil under the Indian sun she earned two pence. That was the regular wage for a woman labourer in those days. There was little that she could give her son, and nothing at all of worldly privilege or opportunity. But there was one thing she could do, and that she did. She surrounded him with her love, but without spoiling him. And that proved to be enough; it gave him security, and the knowledge that he was wanted. The humble life of the poor woman gave out love, and it won back love in full measure. To the end of her life, the son respected and loved her, and to this day honours her memory. When I meet him, he seldom fails to talk about her. When he grew a little older he attended the village school I have already mentioned. A little later, with the help of Mr. Richard Hickling, the veteran missionary of Chikballapur, he was admitted to the L.M.S. Boarding Home for Boys in Bangalore. When the boy was seventeen, Mr. Hickling was bent upon his working in the hospital, and wanted him to be trained as a male nurse. The nursing superintendent was cautious. Responsibility for the training rested entirely with her, and she was doubtful whether his knowledge of English was equal to it. In the end, as often happened, Mr. Hickling had his way; and in 1931 the boy joined the nursing school and started his training. He was

THE TOUCH OF CHRIST

always very anxious to learn English, and in this a number of missionaries, and more often their wives, helped him. He was a rather mischievous boy, but good-natured and reasonably industrious. He completed his course and passed his nursing examinations without much difficulty. As I remember him, he was a tall, rather thin, athletic young man and quite good at games. I think he always had a feeling for people and was genuinely anxious to help them. For five years, or perhaps a little more, he worked in our hospital. We then thought it was time he had a change and widened his experience. It was not without a good deal of lamentation that he was persuaded to make the change, but eventually he did it. For the next three years he worked in a Roman Catholic hospital. And now, for more than twenty years, he has been in government service, and has worked in the largest government hospital in Bangalore — a hospital which is also a teaching school for medical students. To be retained in one hospital for twenty years is of itself a considerable achievement. Those who are familiar with Indian government practice will know that, generally speaking, a government servant is not allowed to remain in one place for more than three years at a stretch. It is an accepted theory that the public is best served by keeping its officers moving. Some years ago he was selected for special training under the World Health Organization in the field of dermatology and venereal diseases; and it is in this department that he still works. Collecting specimens for examination, taking skin clippings and tissue smears in suspected leprosy cases, making ointments and other dermatological preparations, keeping the records of the department are all part of his responsibility.

Day after day, year in year out, quietly and conscientiously he does his responsible work, helping the patients and assisting the doctors. Most significant of all is the trust and respect which he enjoys in the estimation of the doctors under whom, and with whom, he works. As one contemplates such a life, moving from its humble origin to an honourable fulfilment, one

HOT SURGERY

feels justified in the belief that it is in the training of nurses like this that the medical mission makes its most valuable and abiding contribution to the country. And such stories are not uncommon. The touch of Christ does make a difference.



Cholum crop

VII

RAJU

To the south of Mysore City, that exquisite capital of the Mysore Maharajas, and lying between it and the Blue Mountains (the Nilgiris) is the Chamarajnagar district. It contains some of the wildest country in the Mysore State. Part of it is a hilly area covered with thick jungle of bamboos and teak forest. Cheetahs—a kind of leopard—are often to be met with even on main roads. Wild elephants range over the hills, and tigers are not uncommon. But the rainfall is uncertain, and when the rains fail, famine comes. It is a poor area, and I have heard it said by people who live there and ought to know, that it is in an almost constant state of famine.

Raju was born in this area, in the village of Bhogapur. Close by is another village, Kastur, where the English Methodist Mission has had a small medical work for many years. The Kastur hospital is a branch of the Holdsworth Memorial Hospital in Mysore City, which is by any reckoning one of the best Christian hospitals in south India. Raju's grandfather, who worked on a coffee plantation, was converted to Christianity some sixty-three years ago. So Raju was born in a Christian family, but a very poor one. His father also worked on the land as a labourer, and he died while Raju was still quite a small boy, leaving a widow with four children to look after. Raju was the oldest of the four. The prospect of the family was bleak indeed. The Rev. W. E. Tomlinson, one of the greatest Methodist missionaries who ever worked in Mysore, and a close friend and intimate co-worker with Mr. Hickling, took an interest in the family and helped to get the boy into the Christian orphanage and boarding home in Tumkur. In the orphanage the boys not only learn the usual school lessons, but also how to cultivate crops. The school has its own lands where *ragi* and other crops are grown. They also have their own bullocks and carts and ploughs. An industrial school is part of the

establishment, and in it some of the older boys are taught carpentry, and they certainly learn to make very beautiful rose-wood and teak-wood furniture.

It was in Tumkur that Raju completed his elementary education. He would have liked to go on to a high school, for his great ambition was to be a doctor, but his mother was far too poor to support him through such a long and costly education, Mr. Brockbank, the missionary in charge of the orphanage at the time, was struck by the boy's character and ability, and took a great interest in him. This interest continued even after his retirement from India. Raju was almost an adopted son, and he corresponded with him up to the time of his death. Knowing the boy's eagerness to be a doctor, Brockbank approached the Chikballapur hospital with a view to getting him trained as a male nurse and offered to be responsible for his full support during the first year. It was agreed that in spite of his lack of high-school education he be admitted to nursing training on condition that he devote four years to the course instead of the customary three years. In 1940 he came to Chikballapur and started work in the hospital. He passed the examinations without difficulty at the end of the four years. Subsequently he went on to do a year's training in dispensing; and then continued to work as a staff nurse in the hospital in Chikballapur.

In 1947 the building of our small daughter hospital at Kowtalam in the Bellary district was completed. The question was, how were we going to staff it? Where were we to find well-trained men and women who would be willing to go and bury themselves in the heat and the dust of the most remote and the most backward corner of the Bellary district? Dr. G. Isaiah a doctor of considerable seniority, who had already served for twelve years in the L.M.S. hospital in Jammalamadugu volunteered to go. He had to have some one to assist him; somebody with experience in dispensing and in nursing. We asked Raju if he would be willing to go. At first he

hesitated. This was a foreign land to him—nearly two hundred miles from Chikballapur, and more than three hundred from his native village. True enough, most of the people there spoke Kanarese, but their Kanarese was very different from the Kanarese spoken in the Chamarajnagar district, and he could hardly recognize it as his mother tongue. Eventually he said he would go for one year and give it a trial. In March 1947 Dr. Isaiah and Raju started the medical work. The wards were not yet quite ready, so they began by doing a little dispensary work. In any case simple village people will not fall over each other to get into a hospital they know nothing about, nor will they be willing to be treated by people about whom they don't know anything. Confidence is a slow growing plant. I joined them towards the end of October in that year to help in getting the hospital ready for the visit of the Minister of Health with the Government of Madras, and for its official opening on the first of January 1948.

My most vivid memory of those early days of the Kowtalam hospital is of rats — innumerable rats. The scene was reminiscent of Hamelin three hundred years ago in Browning's famous *Pied Piper* . . . The rats sported round one by night, and one appreciated the protection of a mosquito net; by day they looked at you through the windows, and disturbed your bathing operations. When you hung your coat on the back of a door they nested in the sleeves; if you hung it on the back of a chair, they ate the buttons off it; if you suddenly pulled open a table drawer, which had inadvertently been left a little open, they leapt out on you. Miss Madge Barrett, the lady missionary who was living in a little house on the hospital compound at the time, indulged her sporting instinct and devoted much of her time to trapping them. Scorpions were only a little less numerous than the rats; and snakes of several varieties came third in the order of pests. No doubt the creatures felt that their own proper domain was being gratuitously and unceremoniously invaded. Miss Barrett's endeavours may have been rewarded because, ten years later, when my wife and I spent nearly a

year and a half in Kowtalam, the rat population had greatly diminished. The survivors of their descendants had become domesticated and friendly. More probably the reduction in numbers was due to the intense preoccupation of the entire hospital staff with keeping chickens. This preoccupation is understandable enough in view of the difficulty of getting meat of any sort in those villages.

At first Raju lived in one of a line of three very small staff quarters. Next door to him lived Premamma Paul, the Bible woman. She being an elderly widow without children of her own took a motherly interest in him, cooking his food and looking after him. In return, he did much for her, carrying her water from the well, chopping her firewood, and so on. On one occasion he saved her from what must have been a terrifying experience. She was returning from a village one afternoon, where she had been visiting some Hindu women, when she was caught in the middle of a field by a sudden violent storm of wind and rain. She could not move, hardly stand. Raju, who was just recovering from a severe attack of typhoid fever, saw her and dashed out, threw his coat over her and brought her to safety. Unless you can appreciate the sudden violence of a tropical storm, you might think the incident was not worth remembering. A few months ago, when my wife and I were in Kowtalam bidding good-bye to our friends, we experienced just such a storm. Black clouds had been banking up all the evening, and were torn across by occasional flashes of lightning, the air was full of the growling of distant thunder. Suddenly with incredible swiftness the storm broke. Jagged flashes of forked lightning lit the sky, and were followed instantly by great crashes of thunder. A hurricane of wind and driving rain swept over the country. The matting screens which are hung round the veranda by day to protect it from the sun were carried away in a moment; the beds were soaked before they could be dragged inside. A panel was blown out of the door of the bathroom. Roofs were torn from houses, trees were uprooted and thrown across the road, iron electric poles

were bent. In less than half an hour the storm subsided as quickly as it had come. Stars filled the sky, and there was an eerie silence.



Tropical storm

Raju's natural and spontaneous friendliness may have been his most attractive quality, but more important than that was his genuine desire to help and to serve people, and his readiness to go out of his way to lend a hand to anyone who was in trouble.

While the hospital was still only a dispensary, and before it was really ready to admit patients, an elderly man — a landlord from a nearby village—came to hospital. He was desperately ill, and it was obvious that he could not immediately be sent back to his village. Dr. Isaiah had him put into a small house that was intended for a staff quarter, and together with Raju looked after him. Dr. Isaiah treated him, while Raju nursed him by night and by day. Gradually the old man recovered; and he was so grateful for all that had been done for him that he promised to give five hundred pounds towards the cost of constructing a maternity ward. Raju he looked upon

almost as an adopted son, and offered to help him with the cost of his wedding when the time should come for him to be married. At the end of the year, when Raju was asked if he was returning to Chikballapur, he said that he did not want to leave, and that this was the place for him. A few years later Raju married Dr. Isaiah's wife's sister; and a very happy marriage it has been. Whether the old man fulfilled his promise, I don't really know.

For the next ten years Raju was both dispenser and nursing superintendent of the hospital. When operations had to be done, he either assisted the doctor or gave the anaesthetic. In the absence of the doctor he had to take full responsibility for the hospital. It is not to be wondered at that he came to be known by some people as 'the little doctor' and his acumen in recognizing what is the matter with patients is quite astonishing. These responsibilities were not of his choosing, but were thrust upon him by the needs and circumstances of the situation. This kind of thing happens all too often in rural India, and compounders and midwives are expected to carry burdens for which they are neither equipped nor trained.

Twenty years ago, when the question of opening a small medical work in this very needy area was first mooted, it was hoped that it might be possible to locate two or three trained nurses in some of the larger villages in which there were growing Christian congregations, and to link these nurses to a small central hospital through regular visits by the doctor. This hope has never really been fulfilled, because it has not been possible to find suitable nurses. But when the Life Boys in the Congregational churches in Britain collected some money and presented us with a Land-Rover, it became possible to start a mobile dispensary service doing medical and evangelistic work around Kowtalam. Dr. Rodney Todman began that work in 1953, but in little more than a year he was transferred to the hospital in Jammalamadugu. No Indian doctor could be found to take his place; and it looked as though the work would have to be dropped when Miss Annie Lawson, a nursing

superintendent of Jammalamadugu, came to the rescue. In April 1957 she had finally to retire, and still no doctor could be found. But if a missionary nurse could do it, why not an Indian? Raju was an obvious choice. For a year and a half he carried on with great enthusiasm. He adhered very closely to the pattern already laid down by Dr. Todman, and followed by Miss Lawson, but was inclined to add more villages to the itinerary, because he could not say 'no' to appeals for help. Moreover, he was willing to go out of his way to visit patients in their own houses. Through this regular touring, as well as through his long connection with the hospital, he became a very well-known figure in the area.

One of the two main centres of the mobile dispensary work is the small town of Halve, ten miles distant from Kowtalam as the crow flies, but not less than fifteen miles by any course that a Land-Rover could navigate. To use the word 'road' in connection with this course would be misleading. Distance is no longer a matter of miles. On 'M1' fifteen miles is only a matter of minutes, and very few minutes at that, but the fifteen miles between Kowtalam and Halve may be a matter of hours. In wet weather the passage cannot be made by anything on wheels. I once set out to do it on a bicycle, but soon returned to where I had started from, with a kind man carrying the bicycle on his head, the wheels of the bicycle being jammed tight with black cotton soil. To wheel it would have meant removing the mudguards. Halve, with a population of about three thousand, is literally devoid of any sort of medical aid, and in wet weather is quite inaccessible even by a bus. Outside the town, in the quarter where the depressed class people live, is a church and a congregation composed of some seventy-three families, and numbering about two hundred and seventy people. In 1958 it was decided to establish a permanent dispensary in this place, and to put a nurse in charge of it, as had been visualized in our earliest plans. For the purpose of the dispensary it was necessary to rent a house near the centre of the town, where it would be

accessible to people of all communities. As he was already so well known in the place, Raju was once again the obvious choice for the job. In November 1958 he and his wife, with their two youngest children, were sent to take charge of the dispensary. They now have five children, but the three elder ones have had to be sent to boarding school. Once in a fortnight Dr. Isaiah goes over in a new jeep provided by the Life Boys to visit Raju, and to see any patients he may have collected for consultation. Apart from this fortnightly visit from the doctor—and even this is not always possible—he has nobody to whom he can turn for help or advice, and must depend on his own resources and do the best he can. Such loneliness, professional loneliness and spiritual loneliness, is difficult for us to imagine.

In early December 1959 my wife and I went to visit him, and to see his dispensary. He told us some of his experiences. His English is still not perfect, but I will render it as simply as I can. 'A woman, aged about thirty-two,' he told us, 'was brought to me. She had been married fourteen years, but had no children. Then she became pregnant for the first time, but after four months, to her great sorrow she had a miscarriage. Ten days later, while coming in from the fields carrying a basket of cow dung on her head, she noticed that her neck felt stiff. That evening she had difficulty in swallowing. By the next morning she could not open her mouth. When they brought her to me she was getting convulsions. She had got tetanus. They were very poor people, and could not afford any anti-tetanus serum. In any case I had none. It was the rainy season, and no bus could get through to the village. I wanted to send her to Kowtalam, but even a bullock cart would not go on account of the sticky black cotton soil. So I kept her in the dispensary and treated her. I gave her injections of paraldehyde every four hours, and also some injections of Epsom salts. With the help of the family we nursed her here. After seventeen days, by the Grace of God, she got better, and is quite well now.'

Then he went on to tell us of another case : 'They brought a girl, aged seven, to me. She was suffering from *cancrum oris* (a hideous gangrenous condition of the mouth, lips and gums). She was very weak. Her mouth was a grin from ear to ear. She could not hold water in her mouth, or swallow. We kept her here, and I gave nasal feeding for twenty-four days. Many times a day we cleaned her mouth. She is better now. Her teeth are all right, but she has no lips.'

Incredible ? Yes, it is incredible. Cases like these might well have taxed the nursing resources of a well-staffed and well-equipped hospital. Most doctors who have had any experience of India will have seen cases of this kind. I have seen many such, but never have I had to treat one single-handed, nor on the floor of a village house.

But this is not all. For most of the months that Raju has been in Halve, he has had to help with the work of the Christian congregation. The pastor of the church was an elderly man and far from well. For weeks together he was not there, and even when he was in the village he was not able to do very much. Frequently it fell to Raju's lot to conduct the services and preach in the church, and act for the pastor in his absence. He was well able to do this because of the experience he had already had in the work of the church in Kowtalam. There he had been a member of the pastorate committee (that is a deacon), church treasurer, and leader of the Sunday school. Sunday by Sunday he cycled down to the church in the heat of the afternoon to work in the Sunday school ; and often on Sunday evenings he cycled out to isolated village congregations to lead their evening worship.

Raju's first Christmas at Halve was a new experience, not only for his own little family—for the first time isolated at this time of festival rejoicing from the close-knit Christian fellowship of the larger hospital community—but also for the Hindu neighbours, who had never before seen any Christmas celebration. Interested onlookers watched the father and mother and

children making their preparations : cutting and sticking bright coloured paper chains for decorating the little house ; setting up the branch of a tree to represent a Christmas tree, and making it gay with paper streamers and a few old Christmas cards ; putting a garland of sweet smelling jasmine flowers round the picture of Jesus ; and then setting up a small cardboard picture model of the Christmas story. When mother had finished her special Christmas cooking, and father had got his *tabala* (Indian drum) ready and the oil lamps and the special Christmas candles lit, neighbours were called in to share the festival with this one Christian family. They listened to the Christmas lyrics sung by all the family to the accompanying rhythm of Raju's *tabala* and heard for the first time the story of the pictures set up there—of the angels and shepherds and wise men, and of the Babe who came to be the Light of the world.

Living, as they do, in the centre of the town, it often happens at night that non-Christian neighbours drop in for a chat, and seeing the picture of Christ on the wall ask questions about Him, and stay to share in the family prayers.

VIII

HICKLING THE PIONEER

RICHARD ANDERSON HICKLING was one of the most virile, vigorous, versatile men I ever knew. At the age of sixty-five, when he was due to retire, and had reached a stage of life when many men might feel that they have a right to relax, he was still bubbling over with energy. The last thing he wanted to do was to retire. His chief desire was to die in Chikballapur, where he had lived and laboured for forty years, and to be buried in the shade of Nandi Hill. He was a linguist, a musician, an engineer, and a preacher; and in all these spheres he excelled. Above all he was a most colourful character. If you had asked him what he was, I am sure that he would have said that he was an evangelist. He had no doubt about his high calling. Yet he prided himself on the fact that he had never been ordained; though nearly everyone spoke of him as 'the Reverend Hickling'. This would have created difficulties in the Church of South India today; but he was a man of his times, and the Church of South India was still thirty years away.

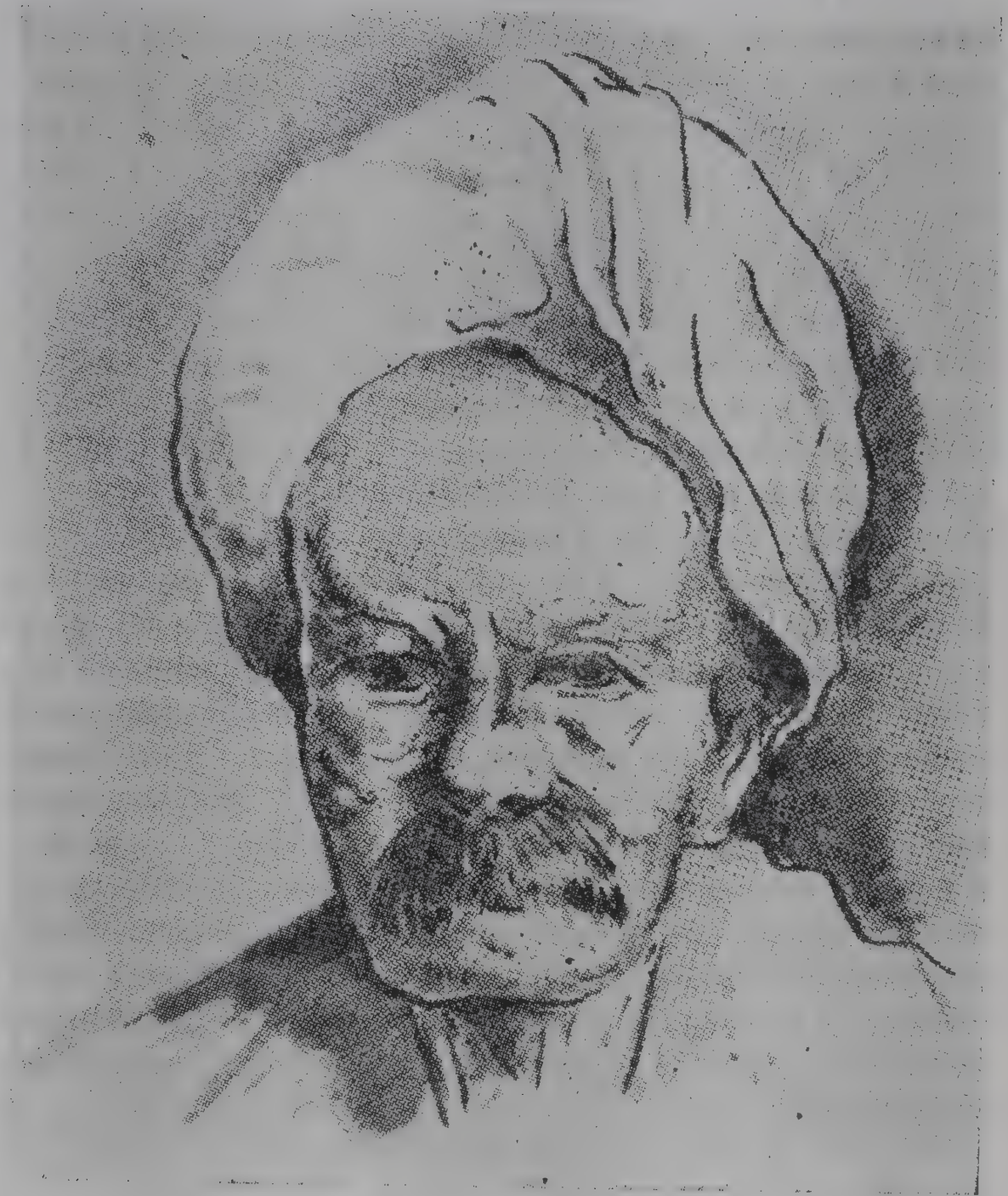
When I became his closest colleague in 1932, he had been in India for forty years. All those years he had been touring the district round Chikballapur, and he knew it more intimately and loved it more dearly than any other man has ever done. Standing next to me in a cattle fair, watching the crowds, the farmers moving among the cattle, and the common country folk going about their business, he suddenly turned to me, and in his characteristic impulsive way blurted out, 'These people, Cutting, these people are the salt of the earth.' He seemed to know everybody, and everybody seemed to know him. When there was a quarrel in a village, he was often called in by both Hindus and Mohammedans to settle their disputes and to compose their differences; such was their confidence in his understanding and in his sympathy. He was perfectly and equally at home in either the Telugu or Kanarese languages;

if he were talking to a Mussulman (a Mohammedan) he would use Urdu. Everything that went on in the town and that affected the welfare of the people he regarded as his business.

One day he was much concerned, because it was said that two foreign *sanyasis* (holy men) had passed through the town, and he had not heard about it in time to meet them. It was thought that they were Americans. Some six weeks later, it was towards the end of May and in the height of the hot season, Hickling received word through the police that two strange men were lying out on the top of a rocky hill in the hot sun, and that one of them was very ill. It was a Sunday morning. Immediately after the early morning service Hickling came to me and said, 'You know, Cutting, I think we should go at once and see what is happening ; those men may need some help. You get some surgical dressings and medical supplies together, and I'll collect a few clothes and some food, and put them in a suit-case.' The hill in question was some fifty miles from Chikballapur, in the most remote and jungly part of our district. My wife and I were due to go to Travancore the next day ; the weather was peculiarly hot, and we still had some packing to do, so I didn't receive the suggestion with any great enthusiasm. But Hickling was full of excitement, and there was no holding him ; so there was no escape. We packed the food and clothes and medical supplies into the old Ford car ; and towards midday we set out. For forty miles the road was reasonably good, but from there on we had to take to field tracks. In six more miles we came to the village of Tolepalle beyond which there was no road at all. The headman of the village, Biappareddy, was an old friend of Hickling's, and he provided us with two coolies to act as guides and to help with carrying our stores.

Only an ill-defined track wound its uncertain way to the hill we were seeking. The country was broken and rocky and covered with low scrubby jungle. Progress was slow. Before we had gone very far we were caught in a heavy thunderstorm.

HICKLING THE PIONEER



'The salt of the earth'

We sought what cover we could find among the rocks, but in a few minutes our light cotton clothes were drenched, and we were wet to the skin. The storm passed as quickly as it had come, and there was nothing that we could do but to press on. We had been told that the *sanyasis* were occupying a small derelict temple at the top. We toiled up flights of steps, unevenly hewn out of the virgin rock of the hillside, till we reached the top. Near the summit we came out upon an open space of slightly sloping rock. At the centre of this was a shrine surrounded by a courtyard and enclosed by a high stone wall. We passed through a small gateway in the wall and entered the courtyard. There we came upon the strangest sight : a well-built, finely-proportioned young man, almost devoid of clothing, was laid out on the rock. His eyes were blue, and but for a beard and long fair hair which hung down to his shoulders, he looked like a Greek statue. His body had been tanned by the sun to a rich nutty brown, the colour of a Brahmin. He had evidently not been expecting us, but, after a somewhat embarrassed greeting, we seated ourselves on the ground beside him. I doubt if Hickling was much embarrassed—he seldom was. We explained our mission, and then asked him about himself ; where he had come from ? And what were they doing ? They had come from Los Angeles and had landed at Bombay some three or four months previously. Since then they had been travelling about, mostly on foot. They had been told about this deserted hill in the jungle by some people they had met on the road, and it sounded to them the sort of place where peace might be found. They were devoting their time to meditation.

‘We are seeking for peace,’ he said, ‘and for a new spirit.’ ‘Why do you think these things are to be found more easily in India than in America ?’ I asked. The reply did not seem to me to be very satisfactory, but they believed that the Indian way of life and the Indian attitude to life were more conducive to peace. ‘Where is your companion ?’ we inquired. ‘He is lying in there,’ he replied, indicating the shrine. ‘He is undergoing a

change of body. It is nothing. When the spirit—the new spirit—fills you, the old body changes, and sloughs off. He will be better. My body underwent a similar change some weeks ago.’ I asked if we might see him. ‘Yes, you may go in,’ he said.

It was dark in the shrine after the bright light outside, but in the dim light which filtered through the open door, we could see the older man lying on a sort of rug. He was very thin, and almost bald. His body appeared to be covered with septic ulcers ; and he had a high fever. On closer examination it was evident that these eruptions on his skin were small blisters that had burst and gone septic. They appeared to me to be the result of severe sunburn, due to lying on the rocks in the heat of the day. We offered to take them back with us to Chikballapur where the elder man at least could be treated in hospital. But they could not be persuaded to do this, and they declined the clothes that Hickling had brought with him. They were, however, glad to accept the bread and bananas and such other food as we had taken, and also the medicines and dressings. Hickling suggested that we should join in prayer before we left, and to this they willingly agreed. And after prayers we bade them farewell.

By this time it was towards evening, and the sun was beginning to set. An evening breeze reminded us that our clothes were still wet from the thunderstorm. Hickling suggested that we might change into the clothes he had brought with him. He opened a case, and out of it produced a suit of lilac-striped pyjamas which had had the legs cut short for hot weather wear. ‘Would you like to wear these?’ he asked. Considering my six feet, and his five feet three inches, I eyed the abbreviated garment somewhat dubiously ; and finally decided against them. ‘Oh well !’ he said, ‘I think I’ll wear them myself.’ And having divested himself of his jacket and trousers, he donned the lilac-striped pyjamas. ‘But you might care to wear this shirt?’ he added generously as he produced a dry shirt from his case, ‘and what about wrapping this towel

round you ?' I didn't want to appear ungracious, so, to keep him company, I removed my wet jacket and clinging trousers, put on the shirt which was several sizes too large for me, and which on me resembled another kind of night garment, and then fastened the towel round my waist. We stuffed our damp things into the suit-case and restored it to the head of the coolie who was standing by smiling amiably. Thus accoutred we were ready to resume our journey. By this time a number of people from the village below, who were of an inquisitive turn of mind, had joined us, to see how we were getting on with their holy men. So it was a considerable procession that set off down the hill. Hickling wearing his large pig-sticker sun-topi on his head (a head covering which is never seen in India today), his striking suit of pyjamas, and a pair of black boots, with his 'pincenez' glasses on his nose, led the way. I modestly fell in behind the man of God.

At the village where we had left the car we were received by the headman and quite a crowd of villagers, who were all anxious to hear about the foreign *sanyasis*. Hickling explained to them that they were Americans who were seeking 'peace', and who had come a very long way in searching for it. 'They think,' he went on, 'it is to be found on a remote hilltop in an Indian jungle, far away from the highways of men.' Then, standing in the courtyard of the great house in the fading light, surrounded by this group of villagers, without the least self-consciousness, in spite of his absurd attire, he told them that 'peace' was not a matter of geography, or of places, or of circumstances ; but it was a state of mind, a condition of the spirit ; and that 'peace' was only to be found in Jesus Christ. 'Peace I leave with you ; my peace I give unto you ; not as the world giveth, give I unto you. Let not your heart be troubled, neither let it be afraid.'

To Hickling it was all perfectly natural. He seemed to be able to take men, wherever they stood, and lead them to the feet of his Master. Standing in a temple in front of an idol talking with the temple priest ; or in a cattle fair admiring

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the cattle and talking to a farmer, or in a market place chatting with a merchant ; he could always make contact with people ; engage them in real conversation ; and lead their thoughts in the direction he most desired them to go.



Going to market

IX

FORERUNNERS OF THE HOSPITAL

WHEN the hospital in Chikballapur was officially opened in February 1913, Hickling had already been in India for more than twenty years. It is difficult for any of us, even those who have known the place well in recent years, to imagine what it was like when he first came. There was no house for him to live in. For more than a year after his arrival, he lived in a tent under some trees. There were very few Christians in Chikballapur in those days, and I think none who actually belonged to the town. There was no electricity, there was no railway ; and there were no cars or buses. The journey from Bangalore—thirtysix miles distant—took at least a whole day in a bullock cart, and half as long in a small horse-drawn vehicle, a *jatka*. Years later Hickling owned the first bicycle ever seen in Chikballapur. He sent a man in to Bangalore to fetch it. Naturally the man could not ride it himself ; it never even occurred to him that it might be wheeled ; he carried it all the way from Bangalore on his head.

The greater part of his first year in Chikballapur Hickling devoted to learning both Kanarese and Telugu ; and by the end of his first year he could preach tolerably well in both languages. 'Hickling had a gift for languages' has often been said. No doubt there is something in it. Of Indian languages, he knew Telugu, Kanarese, Sanskrit, Urdu, even a smattering of Tamil ; and three European languages as well. If he did have a 'gift' for languages, it was a gift that was given to a man who worked very hard at them. In that first year he spent a dozen hours of every day at work on them. They were hours that repaid themselves a hundredfold in the years ahead—giving him an ability to understand Indians, and to communicate with them as very few Europeans could. Even after forty years in the country, he was not too proud to spend his leisure studying with a *pandit* (a scholar and teacher).

'Our people' was his usual phrase when speaking of the people of Chikballapur and the surrounding district. If in any sense they belonged to him, he also belonged to them. He and they belonged to each other. Nothing affected their welfare that did not affect him. Anything that hurt them, hurt him. He was greatly distressed by the disease and suffering which he saw in the villages and in the homes of the people. Very early, Hickling and Mrs. Hickling started a small dispensary in their own home ; and soon he gained a considerable reputation as a doctor. 'I used to keep a large medical book on the table,' he told me. 'The sight of the book seemed to increase people's confidence.' Writing about the dispensary in one of his reports, he said, 'We have had the usual large proportion of cases about which we knew next to nothing. We have told the people so freely, and have begged them to go to the government dispensary in the town. When, as frequently occurred, they refused, to save them from going without help at all, we have drawn our bow at a venture, they have been ridiculously encouraging. They have found indications of improvement, when these were anything but strikingly apparent, and when we have, in the end, tried to be resolute about the dispensary, they have used all sorts of inducements to get us to have another try.' Such was their confidence in Hickling that many years later, when his dream of a Christian hospital in Chikballapur had become an accomplished fact, and T. V. Campbell and his wife, who was also a doctor, and who had already been in India for twenty years and enjoyed a wide reputation in Jammalamadugu, were appointed to Chikballapur, it was with some difficulty that Hickling was able to persuade people to transfer their confidence to the new doctors who had recently arrived. Perhaps they didn't keep a sufficiently large book on the table.

In my early days bubonic plague was still a regular visitant to our town and district every cold season. But it was never as severe as it used to be in Hickling's early days. Its appearance struck terror into the hearts of our people. Hickling and

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Mrs. Hickling used to visit the patients suffering from plague in their own houses, and when necessary they also prepared food for them and took it to them. They moved freely and fearlessly among the people, doing anything they could to relieve their distress and to inspire them with courage. Perhaps they did do 'little good' as far as the plague was concerned ; but such courageous, unselfish service spoke a language that none could fail to understand, and that was not easily forgotten. It went a long way to break down the resistance to the coming of the Christians which was not uncommon in the early days. These events were an earnest of things to come—forerunners of the Christian medical work which has since been carried on in the hospital for nearly half a century.

X

WHAT IS MY JOB ?

HICKLING will be remembered by many of the people who knew him best for his pithy penetrating sayings. Everything about him was vigorous ; and not least his quick epigrammatic speech. Although I was his colleague for only a few months, some of his sayings will always live in my memory. 'Learn to live on the country, Cutting, learn to live on the country.' By that I think he meant you must learn to eat whatever the country can provide, not be dependent on English food, or on anything that has to be imported from outside. 'When there's a bit of trouble about, always remember that's what you're here for' ; or again, 'When you see a job that needs to be done, that's your job.' Here is wisdom distilled from long years of missionary experience. Alongside these sayings I must put one which was directed to me by my commanding officer on my first day in France in World War One. 'You must never ask a man to do what you're not prepared to do yourself.' These concise and pithy aphorisms may represent an oversimplification of any particular matter which you may have on hand, but they are all worth remembering as maxims for missionaries. They have certainly been a guide to me when there was a difficult decision to be made, or a peculiarly disagreeable job to be done. I can well remember, for instance, the night when, with the help of a nurse, we had to bury a body which was in such a revolting stage of decay that the 'sweepers' refused to touch it ; also the day when, along with some greatly protesting 'sweepers', we had to disinter a body which had been buried for several days, because the police wanted to identify it. With great temerity the 'sweepers' had pointed out to the police inspector that it was within the rule of their community to bury people, but not to dig them up again. The police remained quite unmoved by this display of religious scruples. 'When there's a job that you see, that needs to be done, that's your job.' Well, it may be.

There is more than one way in which we can make known the freedom we enjoy in Christ. The following incident may serve as an example. It was a damp, chilly evening in late November, an evening more reminiscent of London in November than of south India, when three men arrived at the hospital. They had been walking all the afternoon from a small village fifteen miles to the north of Chikballapur.

Speaking quickly in Telugu, they said, 'Do us the favour, doctor, of coming immediately to our village.' 'Why, what is the trouble?' I asked. 'There is a woman there who is having a baby, and she is very bad.' 'You should have brought her to hospital.' I replied. 'It is not possible to do much in a village, and without proper assistance.' 'But she is very bad,' they insisted. 'If you would only come and see her first, then we might, if necessary, try to bring her.'

Loath as I was to turn out, I could hardly circumvent that piece of obvious wisdom. I put my old black medicine box, which must have travelled with me well over twenty-five thousand miles, into the car, and we set out. For most of the way the road was not bad, but we could not take the car right into the village. We eventually left it under a banyan tree and completed the journey on foot. It was now drizzling steadily, and the whole countryside was shrouded in grey mist. As we approached the village, I could hear the sound of wailing, and was afraid the woman was already beyond our care.

They took me at once to the house, which was little more than a hut, where the patient lived; and it was immediately evident that my fears were justified. The poor creature was already dead. I suspected that she had finally succumbed to their ill-directed and violent efforts to deliver her. But the baby was still not born. 'She only died a few minutes ago,' they said. A quick examination made it clear that the baby, too, was dead. I turned to go home again, but they pressed me to sit down for a little while and talk. So we went and sat down in the veranda of a rather larger house which was close by. The

relatives and the village elders sat round me on the ground. I told them about the advantage of ante-natal care and tried to impress upon them the importance of seeking medical help early.

After a little while I rose and said that it was getting late, and that I really must go now. 'Don't be in a hurry,' they urged, 'just wait a little longer, and we will get you something to eat.' 'No, thank you,' I replied, and tried once again to get away. But they insisted that I should wait a little longer. Patience, in India, has a very high priority in any conceivable list of virtues, so I sat down again. After a further quarter of an hour again I got up to go, this time with rather more resolution than before, but it was clear that they were still not ready for me to leave. It is rarely polite to come to the point of a conversation too quickly, but as I now appeared determined to go, and the requirements of etiquette had been fully satisfied, out they came with the request that they had had in mind all the time. 'Before you go, please would you take the baby out of the woman? We can't bury her with the baby still inside her.' The request did not come to me altogether as a surprise, as I had met this custom before. If I had refused, they would have had to employ a man from a caste of barbers to do this for them. In carrying out this office he would become ceremonially defiled and would not be able to carry on his ordinary business, nor would he immediately be able to return to his own house and family. He might even have to be out for as long as six months before he could be reinstated. During the whole of this time the people would be responsible for his support, and it was likely to become a pretty costly business.

I had with me my medicine box, and it contained a few surgical needles, and some silkworm-gut for emergency purposes, but no other instruments. 'But,' I protested, 'I have no instruments here.' 'What do you want?' they inquired. 'Well! I shall want a knife of some sort,' I said. 'Then we will get you one,' they replied helpfully. Presently they produced one — a slightly curved and fearsome looking weapon

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which had obviously been designed for agricultural pursuits rather than for surgery. I remember that it was reasonably sharp. Armed with this, they led me back to the house where the body was lying on a low string cot. They thereupon retired, and left me to it. The only illumination in the house came from a hurricane lantern which was suspended from the roof and dangled just above my head : and the only spectator was a cow which peered inquisitively over my shoulder. The operation, and subsequent repair, didn't take many minutes. I called for some water, which they brought me. After washing myself, I again prepared to depart.

This time I really did get away. They escorted me back to the car with protestations of extreme gratitude. 'Having gone, you must come again!' they shouted in the polite Telugu idiom. And having climbed into the car I drove away. As I drove back to Chikballapur through the dark damp night I mused, 'Is this part of a missionary's avocation?' and Hickling's words came to me, 'When you see a job that needs to be done, that's your job.'

XI

FEVER

DOCTORS, and occasionally other people too, ask you, 'What are the most common diseases you see in the area where you have worked?' At one time I should have answered, without the least hesitation, 'fever'. Those who have been initiated in medical matters might well reply, 'But fever is not a disease.' That's true enough, fever isn't really a disease but is probably the symptom or sign of a disease, the body's response to some disease, the signal that all is not as it should be within.

Whenever I examine a patient for the first time, after having asked him about his present complaint, and how long he has had it, and having made some preliminary inquiries as to its possible origin, I generally go on to ask him about any other diseases he has suffered from during his life. As often as not he replies that he has never had any other illness, at any rate none that he can remember. It is then necessary to prompt his memory by asking some more leading questions. 'Have you had any fever at any time?' I always remember one man's answer to that question, 'Naturally,' he said, 'I get fever from time to time.' Fever is such a commonplace of life that it has come to be accepted as part of the nature of things, and as such, it is disregarded. There are millions of people in India who never know what really good health is.

Sir Ronald Ross, who did so much to disclose the cause and the mode of transmission of malarial fever, once estimated that not less than a million people died in India every year as the result of malaria. Due to the work of Sir Ronald, and many others, conditions have improved greatly since his time, but malaria still remains today a great menace to the advance of civilization. India realizes this all too well, and has set down as one of the aims in its 'Third Five Year Plan' to eradicate this disease from the country completely. To anyone who has known India in the past, that sounds an utterly extravagant

ambition; but already great strides are being made. Some months ago the medical officer in charge of the anti-malarial campaign in the Mysore State came to see me. As he unfolded the plans that he had in mind, he was bubbling over with enthusiasm. It was his intention to solicit the help of every medical worker in the whole state; and to attempt to follow up every unspecified case of fever which comes under observation in any hospital or dispensary, or may be seen by any practitioner of medicine. Even so it must be remembered that the vast majority of sufferers in India's seven hundred thousand villages never come under any real medical care at all.

We spoke of deaths which resulted from malaria, not of people who died of malaria. The distinction is not unimportant. There are some forms of malarial fever, such as cerebral malaria, which may kill a man swiftly, but these are relatively uncommon. For the most part it is a long struggle against increasing weakness and anaemia. Thus malaria is not a dramatic or terrifying illness. Gradually increasing weakness and loss of vitality reduce the people's capacity for work. And when people cannot work, they cannot earn; so that undernourishment, and even starvation, quickly follow; and they become an easy prey to any other infection to which they may be exposed. So malarial fever is a disease of enormous economic as well as human significance.

One of the most striking features of this disease is the way in which it ebbs and flows from season to season, and from place to place. Generally the Chikballapur district is relatively free from malarial fever, but I have known seasons when it went through our area like a pestilence. One particular season stands out in my memory. It had been an unusually wet year. As a result of the 'good rains' the tanks were full, and the crops were exceptionally heavy. Even the farmers were inclined to admit that the harvest was likely to be 'nine pence in the shilling'. The word 'tanks' may be misunderstood by anyone who is not familiar with the Indian scene. It does not refer to some sort of galvanized iron water container, but to large

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reservoirs of water which resemble artificial lakes. These are formed by constructing long embankments across sloping ground, so that the water which falls during the 'rains' is caught and retained. The construction of such tanks is an ancient device in India, and they are a familiar feature of the countryside. The largest of them may be many miles in length. In Telugu people sometimes use the same word for them as they do for the sea.

The largest tank in our district, when full, is something like ten miles in length, and the water covers many square miles. In the autumn of the year that I am thinking about, reports were coming to us that fever was very severe in a number of the villages along the shores of this particular tank. So we determined to visit the area to see if there was any way in which we could help. As we walked from village to village it was evident that the condition of the people was miserable in the extreme. Fever, weakness and the fear of fever had sapped their strength and crushed their morale. In every place they clustered round us asking for help, and there seemed so little that we could do. The need was obviously so far beyond our slender resources. 'There are a hundred cases of fever in this village,' they told us in one place. 'Half the village is laid down,' they said in the next. In a third village they pointed to the crops, which were standing ready to be harvested, and said, 'We are too weak to gather it.' We gave them such pills as we had, and promised to represent their case to the Government, and this we did. The Government did send them help. Visiting the same area five months later, in the hot weather, we found that the fever had completely subsided.

A more intimate story may help to bring into focus for us the economic effects of this widespread disease. Some years ago the Government of Mysore brought into being a very large irrigation scheme. An immense concrete dam was thrown across the Cauvery river some miles above Srerangapatnam, the ancient capital of Mysore. The name of the city, by the

way, was corrupted during the time of the British occupation into Seringapatam, and has recently been restored to its original form of Srerangapatnam. The original name meant something ; the corrupted form is no more than a jumble of letters devoid of all meaning. A vast reservoir of water was thus formed during the rainy season. This water was then channelled by means of an underground canal, the Irwin Canal, under a range of hills to irrigate the lower lying district of Mandya. By this means thousands of acres of land were brought under cultivation, and it became possible to grow large quantities of rice and sugar-cane where little or none grew before. To deal with the new crops of sugar-cane, at the centre of the district, a great sugar factory was established.

At the time this was going on a Christian family, who owned a small property, were living in a small town near Chikballapur. The family decided to sell their house and land and move into the Mandya district to share in the new prosperity that had come to that area. They bought some bullocks and a cart or two and set out for the promised land flowing—not with milk and honey, but with water and sugar. They knew that bullocks and carts were in great demand and hoped to make a good living transporting sugar-cane from the farms to the new sugar factory. Things went well for a time, but not for very long. One member of the family died of cholera ; and then came fever. The water from the Irwin Canal brought with it not only prosperity, but a terrible epidemic of malarial fever as well. One member of the family after another fell sick and was unable to work. One by one the bullocks had to be sold ; and the carts followed them. The family, which formerly had been relatively well off, was reduced to a state of utter poverty. Not only had they lost their small property, but their health as well, and with their health had gone their capacity to work and to earn a living. Multiply that pathetic little story a thousand or ten thousand times, and you get a glimpse of what malarial fever means to many people.

FEVER

Today we have far more effective weapons with which to combat malarial fever than were available even thirty years ago. The Government of India, with the help of the World Health Organization, is making strenuous efforts to eradicate the disease. The enemy is in retreat, and we hope may soon be in full rout. We have had some share, if but a small one, in this war. At least we have been able to lend a hand to a few of the fallen.



Malaria

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XII

BUBONIC PLAGUE

READERS of the Old Testament in the Authorized Version may be excused if they are a little puzzled about a peculiar disorder which overtook the Philistines after they had carried off the Ark of God and had lodged it in the house of their god Dagon. Dagon himself appears to have suffered a good deal on account of this action—see the first book of Samuel, chapter five and verse four. But the account goes on to say that the hand of the Lord was heavy upon the people of Ashdod, ‘. . . and he destroyed them, and smote them with *emerods* . . .’ When the people consulted their priests and diviners as to what they should do with the Ark of the Lord, the advice given was that they should get rid of it with the least possible delay. ‘But,’ said the diviners, ‘don’t send it away empty.’ Along with it they were to send a ‘trespass offering’. The offering suggested was even more curious: ‘. . . ye shall make images of your emerods, and images of your mice that mar the land . . .’ and send those along with it. Clearly the diviners must have felt that there was some connection between the mice and the ‘emerods’ with which the people were suffering. Modern translators of the Bible come to our rescue by replacing the word ‘emerods’ with the word ‘tumours’ (see the Revised and later versions). This helps a little, but they might have gone further and used the word ‘bubo’, thus making the reference to ‘bubonic plague’ even more explicit. This early association between rodents and a disease which is marked by painful swellings in the groin and elsewhere is very striking. It is now well established that this terrifying disease is really a disease of the rat family, and that men only become infected, as it were accidentally, and only through the agency of a certain kind of flea which carries the deadly germ from the rat to man. Every schoolboy in India knows that there is some connection between the unexpected death of rats and the spread of plague; so that when they want a couple of days holiday a dead rat is unaccountably found in one of the classrooms.

BUBONIC PLAGUE

The great plague, or the 'Black Death', as it was called, which visited London in 1664-65, carried off upwards of 70,000 people out of a population of some 460,000. Philip Manson-Bahr suggests that India has suffered more from this disease than any other country. 'There have been years,' he writes, 'when the plague deaths exceeded a million. The highest death rate was reached in 1907 when it was considerably above that figure, and it has been estimated that from the time of its introduction into India until that date there was a total of nearly ten million deaths.'

An epidemic usually begins in the cold weather — more especially if it has been a wet season. Rat fleas do not like very hot weather, nor do they like very dry weather; but they do not like very cold weather either. So the climate of the Mysore State is admirably suited to fleas. An epidemic is almost always preceded by reports of 'rat falls'. That is to say dead rats and dead squirrels are found lying about the ground or in the roofs of houses. During one epidemic we found ourselves under the necessity of taking the roof off our own bathroom. When the tiles were removed, three or four dead squirrels were discovered. The house had to be evacuated for at least one month, and thoroughly fumigated. When a dead rat is found it is usually best to pour paraffin oil over it, and, if it is at all feasible, burn it where it lies. As soon as the municipal office is informed that dead rats are being discovered, it embarks upon a campaign to exterminate as many rats as possible. The usual measures adopted are to block a number of the rat holes, and to blow cyanide gas into the remaining holes. Town criers with drums are sent round the town to advise people to be inoculated against plague; and a number of centres are set up at which this can be done. This is usually the point at which the authorities turn to us for help. Many people come to hospital to be inoculated, and members of our staff go into the town and surrounding villages to help with inoculation work there. Most people nowadays realize that being inoculated gives considerable measure of protection

against the disease; but that is not to say that everyone is willing to be done. Of all the different kinds of inoculation that are now available the anti-plague inoculation seems to cause the most severe reaction, especially when the large single dose method is adopted. Generally we must depend upon this method, because it is practically impossible to get hold of people a second time after an interval of a week or ten days.

It is in the care of the people who have already fallen sick that the authorities chiefly seek our help. In a country place like ours, it is only the Christian hospitals that can offer any real nursing care. Even we find it desperately difficult to get suitable accommodation for isolating such patients. Once the patient suffering from bubonic plague has been taken from his surroundings, and has had all his clothes removed and disinfected he is no longer highly infectious, but people will not believe that, and once plague patients are admitted to hospital, other patients run away because they are afraid. Government hospitals often have definite regulations against the admission of patients suffering from infectious diseases. In cities special provision is made for epidemics of this kind, but what of the villages, where four-fifths of India's population live?

Just before my wife and I left India, some hundreds of people came to say good-bye to us. Among them was a middle-aged man. In the peculiar way that sometimes happens, his name and his village came to me in a flash. 'You are Venkata Reddy of Buragmadugu,' I said, 'Yes,' he replied. And I remembered the occasion of our first meeting. It was late autumn and the time of the *rāgi* harvest. His old father, Adi Reddy, was an in-patient in our hospital at Chikballapur at the time. Adi Reddy was a landlord, the owner of a large property, and a man of considerable standing in his own village. One day news was brought to the old man that a number of people in his place were down with fever, and that two of his sons and a grandson were among the sick. He

BUBONIC PLAGUE

insisted that he must go home at once, and asked me to accompany him, so that I could see the position for myself. I suspect that he must have known what was the matter, though he led me to suppose that it might be malaria. Possibly he thought that if I had known the truth, I might have refused to go with him. By road, his village was rather over thirty miles distant from Chikballapur. I went in the hospital car and took him with me. As so frequently happens, the road didn't go all the way, and we had to do the last two or three miles on foot.

When we reached the village, which was only a small hamlet set among rocky hills, I was surprised to discover that it was completely deserted. Immediately I realized that there must be plague in the village, and that the people had left it. That is by far the wisest thing to do. They had built for themselves small temporary shelters made of straw and the branches of trees; and these were dotted about over the hillside in the shade of rocks and bushes. We found the old man's eldest son, Venkata Reddy, lying in one of these shelters, and a younger son, Gangi Reddy, in another one at some distance from his brother. Venkata Reddy appeared to be severely ill. He had high fever, his eyes were bloodshot, his tongue dry and coated. He had several bubos, and two of these were already starting to suppurate. He was far too ill to move, and the outlook appeared grave in the extreme. Gangi Reddy was a well-built young man of about nineteen. He, too, had fever, but he had only one bubo, and he appeared far less toxic than his brother. He was even able to get up and greet us. There were a number of others lying round equally sick, and already there had been several deaths in the village.

In those days there was no specific treatment of plague. Sulphathiazole, an early member of the family of so called 'sulpha' drugs, had just been introduced, but its use in plague had not been fully tried out. In any case it was still very expensive and extremely difficult to procure in India. Penicillin and all the other anti-biotics did not come into anything

like regular use till ten years later. I had with me a few sulphathiazole tablets—perhaps two dozen; but what use were they among so many people? I decided to give all that I had to Venkata Reddy. I made him take four of the tablets immediately, and impressed upon his relatives that he must be made to swallow two more every four hours. The father decided not to return to hospital and to remain with his people, but promised to send a messenger into Chikballapur the following day for further supplies of tablets. With a heavy heart I turned and made my way back to the car. As we passed through a small field of *ragi*, one of the villagers who was accompanying me said, 'There is no one to harvest this *ragi*, the family who own this field are all dead.' The mortality rate in those days in most epidemics of plague was about fifty per cent of all people who were attacked.

Adi Reddy did send for more pills, but a few days later I heard that Venkata Reddy, who seemed so desperately ill, was better, but that his younger brother, who had seemed comparatively well, was dead, and so was the small grandchild. How many others died in that village I never knew. This is what plague means in an Indian village: pain, sickness, fear, despair, and for many—death. Great strides have been made in our knowledge, but knowledge, as such, is not much help unless there are people who are ready and willing to carry that knowledge into the places where it is most needed. To be willing to do it, and to have some share in that work, may be to bear witness to Jesus Christ, though never a word be spoken.



Deserted village

XIII

CHOLERA

CHOLERA. Does that word evoke any feeling or emotion in your mind? May be not. We may not even have heard the word. If we have heard it, we may think of it only as a disease which occurs from time to time in India or in the Far East; in any case as something pretty remote from our ordinary lives in this country. If that is so, it is something for which we should be profoundly thankful. In India it is a word which can strike terror into the hearts of most people, and, I confess, I must include myself among them, because it once touched me intimately; as it must have touched thousands of Indian families.

When I was barely six years old, I lost my only sister from this dread disease in a single night. We were living at the time in a small hill station in the foothills of the Himalayas. She was two years younger than I was. One evening we were playing together under the pine trees in our garden; the next day she was gone. All I knew at the time was that during the night she had been taken seriously ill, and that I must not see her. Before midday she was gone.

That is exactly what happens in thousands of cases. Cholera is a disorder which strikes swiftly and without warning, and is, on that account, the more to be dreaded. When a case of cholera is reported to you at any hour of day or night, it is no use saying, 'I'm busy at the moment; but I'll come and see it in the morning,' As likely as not, before morning the patient will be dead. If anything is to be done, it must be done without delay. In cities provision is made for emergencies of this kind. In Bangalore there is an epidemic diseases hospital, where cases of this kind can be admitted at a moment's notice, and where they can be isolated, so that they are no longer a source of infection to other people. A special staff and special equipment are held in readiness all the time. But what of the

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rural areas? In an under-developed country like India the conditions in urban and rural areas are utterly different. Let us look at what can, and often does, happen.

I had been attending committee meetings in Bellary, and was on my way back to Chikballapur. The overcrowded bus in which we were travelling was a so-called charcoal-bus. On account of the difficulty of getting petrol during the war, charcoal was being used as fuel in its place. It was not very efficient, but it was better than nothing. Even on the relatively flat country that we had been crossing for the past hour the bus had been making slow progress, grinding along at fifteen miles an hour and lurching from one side of the road to the other. When we reached the 'ghat section', the steep and winding road that climbs up on to the plateau on which Chikballapur is situated, it was obvious that the ancient and groaning vehicle was not going to 'make it' without some assistance. All the male passengers were asked to get down and walk, and, if necessary, give the bus a push. I descended with the rest of the men. I suppose there were about twenty-five of us. Even so the bus, which was licensed to carry twenty-eight passengers, still appeared to be packed with the women and children who remained in it. One of the men with whom I was walking casually remarked, 'They say there has been an outbreak of cholera in Sidlaghatta.' I pricked up my ears immediately. Sidlaghatta is only ten miles from Chikballapur, and if this report was true, it would not be long before the cholera reached Chikballapur. 'Sixty people have died already', added another man. It seemed to me unlikely that the figures would be accurate. 'But,' I thought, 'there must be some truth in the rumour. The question is, how much truth?' It was a lovely evening as we climbed the hill, following in the wake of the bus, the setting sun throwing long shadows in the road in front of us. None of us could realize then the horrors that the next few weeks would hold for us.

On arriving in Chikballapur, I learnt that the rumour I had heard was all too true. First thing next morning I dispatched

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our hospital messenger, Mohamed Peeru Sahib, one of the most faithful men I ever knew, to the public health authorities in Bangalore to obtain supplies of anti-cholera vaccine. We then proceeded to inoculate the entire hospital staff with their families and dependents against cholera. Within the next day or two we heard of the first cases in Chikballapur and nearby villages. No doubt it was being spread by the people who had run away from the stricken area.

Religious festivals are the most common source of epidemics in India. Multitudes of people gather at the holy places, like Benares in the north, or Thirupathi in our own area. It is there that they contract an infection, and it is from there that they carry the germs back to their own villages. Quite recently there was a small outbreak of cholera in a group of villages a dozen miles from Chikballapur, and the source of infection was easily traced back to one woman. She had been on a pilgrimage to Thirupathi; soon after getting home, she fell ill. Another woman who was living in the same house, and who was pregnant, left the house and went to live in another village two miles away. There she fell ill. Within a week or ten days there were twelve deaths in that village.

We all know that cholera is spread by means of contaminated food or polluted water supplies; but this is not realized by most Indian villagers, and even if they do know it, they hardly know what to do about it. More often the epidemic is thought to be due to the displeasure of a goddess or an evil spirit; and what needs to be done is to propitiate the offended goddess. We know that women are more liable to infection than men, but we do not suppose that is because women are greater offenders than men, but because they never eat until their men have had their meals. Their food, therefore, is more likely to be cold, and it has had a longer time in which to become contaminated by flies. Poor and ill-nourished people are more prone to infection than strong and healthy ones; beggars, who go round from house to house collecting left-over scraps of food, are in a position of peculiar danger:

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Soon the number of cases in Chikballapur began to rise. Forty were reported, of whom eighteen died. Our doctors and nurses were going round to the stricken houses in the town giving what help they could. Due to the severe diarrhoea and vomiting patients often collapse within an hour or two of falling ill; and it is of particular importance to try to tide them over this critical period. This is best done by running into their collapsed veins two or three pints of a hyper-tonic salt solution. To make the salt solution large quantities of distilled water are needed. We have in the hospital a small 'still' and this was kept working day and night making distilled water; and the operating theatre staff worked continuously preparing and sterilizing the salt solution. At that time our hospital was the only place from which supplies of the life giving saline solution could be obtained; and the amount that we could prepare was very limited. The government doctor and other practitioners in the town all turned to us, and again and again our small stock ran out. The anti-biotics were just beginning to appear on the Western horizon, but they had not yet reached India. To run two or three pints of fluid into a patient's vein, which seems so easy in an English hospital, was no small undertaking with the equipment we then had, and with the patient lying on the floor of an Indian house. Most patients refused to be moved from their houses, but there was no place to isolate cases who really had no home, and who were lying in some public lodging-house. We considered closing our own hospital as a general hospital, and converting it temporarily into a cholera hospital; but we had no place in which to put our ordinary patients, some of whom had come from distant places.

Adjoining our hospital there was a government women's dispensary, and there they had a very small building which was standing empty. It was at a little distance from the other buildings, and I think was originally intended as a mortuary. The government lady doctor was very willing to do anything she could to help us, and she readily gave us permission to use this building. We converted it into an isolation ward, and

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we supplied all the necessary staff and equipment. Even so it was not possible to get more than three patients into it at a time. Later on, the nursery school, which stands between the hospital and our own bungalow, was converted into a cholera hospital, and this served our purpose admirably.

Soon we received complaints from people who were living near us that by bringing patients out of the town we were spreading the infection, and that in any case we were bringing the cholera too near to their houses. The municipal president, who was a friend of mine, and who was very anxious to be helpful, came to me and said, rather apologetically, 'I'm afraid you will have to move those patients, the people round here are complaining.' I fear I was a little short with him; and after explaining that a disease was not spread by isolating patients I said, 'You can go and tell them that if they don't like it, we will move the patients into the townhall, and they can look after them themselves.'

The people concerned then wrote to the district medical officer, asking that the patients be moved. He replied by giving instructions that all cholera patients must be removed from the premises of the government dispensary, as it was against the rules to admit infectious cases to government dispensaries. To this we replied rather more politely, that we should be glad to carry out his instructions as soon as he could come over from Kolar (which is forty miles away) and tell us where to put them. He did in fact come over, and was most helpful and gave orders that the weekly market, the food stalls, and the coffee shops be closed.

In house after house that I visited, I asked the same question, 'How do you dispose of the vomit and the excreta, and what do you do with the soiled linen?' And in nearly all the houses I received the same answer: 'We just throw the excreta into the gutter outside, and the linen we wash in a nearby tank.' It would be difficult to conceive of measures better calculated to spread infection.

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One afternoon—it was, I remember, a Saturday and early in the epidemic—a boy, aged about twelve, was left lying at our hospital gate. He was obviously suffering from cholera. We made inquiries about him and learnt that he had a mother in the town. We told her that we were very sorry, but we had nowhere to admit him, and that she must take him home. Later in the evening I went to find her house. I discovered that she was a widow with five children. The sick boy was the eldest of the family, and the whole family were living in a poor little house consisting of only one room. The second boy, who was about a year younger had run away when he knew that the older boy had cholera. I then went and fetched the chief officer of the municipality and the town sanitary inspector, and together we went to review the situation. But, beyond giving them some medicine, there seemed to be little that we could do about it. I hardly expected that the boy would live till the next morning. But on Sunday morning he was still alive, and we sent some further supplies of medicine. That evening I went to their house again, and found that the boy was still hanging on. On Monday morning the mother came to hospital and reported that the boy seemed rather better, and took more medicine with her.

In the afternoon I was sitting in the out-patient department, with the municipal president sitting beside me. He had come to tell me that his servant was down with cholera, and to ask me to go and see him. 'I'm not going to leave you till you have been to see him,' he announced. I got rid of the other patients as quickly as I could, and then, with a male nurse to help me, we set off in the car for the servant's house. It was in an area in which cholera was particularly bad. We found the young man lying on the floor, for there was no cot in the house; and immediately we proceeded to transfuse him with hyper-tonic salt solution. By the time we got to the end of the first bottle his pulse, which before we could not feel at all, was beginning to return; and before the second bottle was finished he had revived considerably. Eventually he made a good recovery, and is still alive today.

While we were still attending to him, some people brought us news that the woman, the mother of the boy, was also down with cholera, and there was no one to look after the children. As soon as we had finished clearing up, we packed our things and immediately went on to that house. A more pathetic sight it would be difficult to imagine. The boy was lying against the wall, but by this time his condition was reasonably good — indeed far better than could have been expected, but the mother was completely collapsed and was almost unconscious. There she lay in the middle of the floor, a heap of rags surrounded with filth. Sitting round her head were the three small children, a girl aged about nine, and two small boys of seven and four. It was getting dark, and the three of them were eating some little bit of food out of a common dish — food that the girl of nine had prepared for them. The house was one of three which surrounded a small courtyard. The people from the other two houses had all run away when they learnt that the small boy had cholera. As we had the hospital car with us, we promptly transferred the three children to that. All three were screaming at the tops of their voices at being thus summarily removed from their poor little home, but the mother did not stir. Having arrived at the hospital, we cleared one small room, and put the three children in it. And then, with two male nurses to help, we returned once more to the woman's house.

By this time it must have been between nine and ten o'clock, and it was perfectly dark. As we got to the end of the little lane, a terrific thunderstorm burst over the town. Rain came down in torrents, and the roof of the car leaked like a sieve. The nurses sheltered in the doorway of a house nearby, while the car-driver and I crouched in the front seat of the car with a blanket over our heads. When the rain had abated a little, we took an electric torch and set out to fetch the patients. To our horror, we discovered the mother lying in a drain outside the house, with water pouring over her. How she had got there we never knew. Possibly she had roused

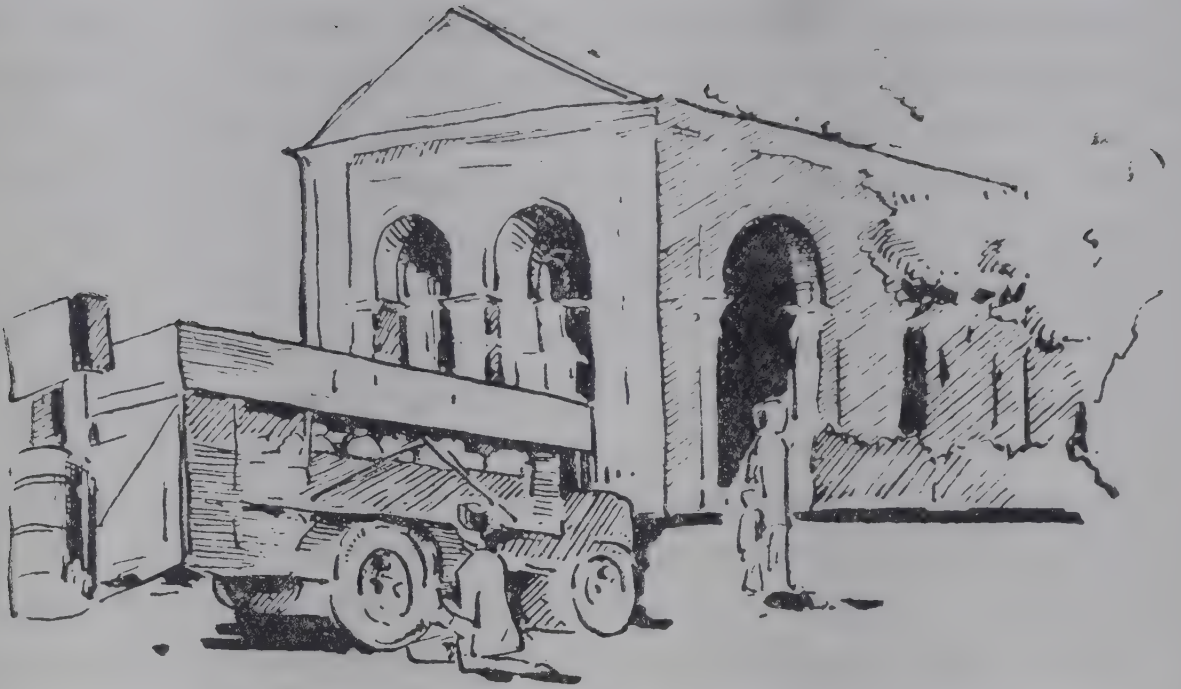
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herself sufficiently to notice that her children were no longer there, and had struggled to the door to look for them, and had then collapsed again. Her few bits of clothing had fallen away from her, and she was lying almost naked in the pouring rain, unable to move. We wrapped her cold body in a blanket and lifted her into the back of the car, and then went back to look for the boy. He was still lying by the wall where we had left him. We removed them both to the small ward in the government women's dispensary. We got more blankets and hot water bottles from the hospital, and that night we gave the woman our two remaining bottles of salt solution; but before morning she died. The next day, one of the other three children also contracted cholera and died, but the boy, who was the first to be ill, recovered. Later we found some other relations who were willing to make themselves responsible for the children. In India it is an almost universally accepted principle, that family loyalty transcends every other kind of loyalty, and it is not often that people will renounce family responsibility.

In that small isolation ward we treated twenty-four cases; three of them proved not to be cholera; and of the remaining twenty-one only eight recovered. The numbers do not sound very large, and the result pretty poor, but it must be remembered that it was only the very poorest people, people who were already half starved, and who had nobody to look after them, who were willing to be admitted to our humble isolation ward. Within a month the epidemic subsided, almost as quickly as it had started; but while it lasted it was as though a hurricane was passing over us. And it made very heavy demands on us both in staff and materials.

In a letter which I wrote to my mother at the time, and which I find she has preserved, I see this sentence, '... no small credit is due to our male nurses. They looked after these unpleasant cases with a good deal of devotion, and without the least grumbling. I don't think there is another group of people in this town who could, or would, have done it.'

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Charcoal bus outside Chikballapur hospital

XIV

AROGYAVARAM - THE TOWN OF HEALTH

STATISTICS quoted for a number of the principal cities in Britain and in Europe show that the death rate from tuberculosis during the last ten years has fallen with startling rapidity in every one of them. In Edinburgh, for instance, in 1957 the deaths from tuberculosis amounted to no more than five for every 100,000 of the population. But there are other figures which are far less reassuring. The World Health Organization estimates that there still must be between twelve and twenty-five million cases of infectious tuberculosis in the world; and the Indian Council of Medical Research, on a large-scale sample survey made in 1959, estimated that in India alone there must be four to eight million cases of active tuberculosis. This means, that even if we admit that the population of India is ten times greater than the population of England and Wales, the incidence of tuberculosis in India is one hundred times greater than in England and Wales. Malarial fever, plague and cholera appear, for the time being at least, to be on the decline; but for tuberculosis, the reverse is the case. Dr. P. V. Benjamin, the very able Indian Christian doctor who is adviser on tuberculosis to the Government of India, has asserted for many years that in India there cannot be less than two and a half million cases of tuberculosis, and that of these at least five hundred thousand die every year. In writing or speaking of India it is easy to talk in terms of hundreds of thousands, and to have little concern for the men and the women behind the facts and the figures. Think of it! These figures mean that more people die of tuberculosis in India every year, than the total population of great cities like Edinburgh or Leeds or Bristol, and twice as many as live in Cardiff or Newcastle.

Even in our small circle, in the London Mission, we have had our losses. Of the first four missionary doctors appointed

by the London Missionary Society to work in Chikballapur, Dr. T. V. Campbell, and his wife Dr. Florence Campbell, Dr. Hockett, and Dr. John Winterbotham, three suffered from tuberculosis contracted in India, and two of them ultimately died of this disease. About one fifth of the patients in our hospital at any one time are suffering from tuberculosis in one form or another.

There is one important respect in which tuberculosis differs from diseases like plague and cholera. While those diseases are dramatic in their onset, and swift in their course, tuberculosis is generally stealthy in its onset, and relatively slow in its progress. Because it can begin with so few signs and symptoms it is peculiarly treacherous; with the result that a great many of the cases we see are far advanced before they come under observation. A missionary friend of mine was over seventy years old, and had been in India for more than forty years, when it was first recognized that he was suffering from tuberculosis. He was a man who had a reputation for being extraordinary tough and almost impermeable to heat. I've known him to travel on the railways in a crowded third-class compartment in the hot weather wearing a woollen suit. He was staying with us in Chickballapur once when I drew his attention to his cough. 'I've had it for seventeen years,' he replied, 'sometimes it's a little better, and sometimes a little worse. Perhaps it is a little worse just now.' While preaching in church, he sometimes seemed to be gasping for breath, but he paid little attention to it. Shortly after that, when he was examined by a specialist, and the diagnosis was confirmed, he said, 'I suppose this is my death warrant.' 'No, I shouldn't think so,' replied the specialist. 'You've probably had it for thirty years.' Several years later he died as the result of a fall in the bathroom when he broke his leg.

There are, on the other hand, occasions when the onset of this serious malady may appear to be sudden, and the course all too short, but fortunately such occasions are not common. Some years ago I was deeply shaken when three young men

died in our hospital within a period of three months. All three were twenty-five years old, and all three died within twenty-eight days of the first sign of the disease. No doubt the treacherous enemy had been in hiding longer than a month, but how much longer, we shall never know. The first of the three young men was a Christian, a law student and the brother of one of our own doctors. He appeared to be a strongly built, athletic young man, and was captain of his college cricket team. He was travelling to Bangalore by train, to complete some arrangements in connection with his marriage when suddenly and quite unexpectedly he had a bout of coughing, and, to the consternation of everyone in the compartment, brought up a large quantity of blood. As soon as the train arrived in Bangalore he was removed to the Victoria Hospital, and there the diagnosis of tuberculosis was made; and he was transferred to a tuberculosis sanatorium near Mysore. He was very ill, and at the request of his father, and because his brother was a doctor in Chikballapur, he was moved to our hospital. Nothing that we could then do was of any avail. He went downhill rapidly, and just within the month he died.

The second young man was a Brahmin, the only son of a government officer in Chikballapur. He was an engineering graduate, and a boy I knew very well. When he was at home we occasionally played tennis together in the evening, and often he would come round to our bungalow to borrow books. This was something quite unusual in an Indian graduate; many of them never open a serious book once they have graduated and left college. For a time he was employed in the Kolar Goldfields; but the parents thought that this was too dangerous an occupation for their only son; so he got a post in the Hindustan Aircraft Factory just outside Bangalore. He was an energetic person, and used to do exercises in the early morning. One morning, while he was doing his exercises he suddenly coughed up a quantity of blood. As they were living quite close to our hospital, his parents immediately sent round for my Indian colleague, Dr. Rajaratnam who went at once to see him,

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and put him to bed. After prayers that morning Dr. Rajaratnam told me what had happened, and asked me to go round and see the boy. When I saw him, he seemed a good deal better, and we kept him very quiet all that day. The following morning we moved him into hospital. As soon as an X-ray picture of his chest was taken, it was all too evident what was the trouble. Again nothing that we were able to do seemed to check the course of the disease. In a month he died.

Tuberculosis is protean in its manifestation, that is to say, it may appear in many different forms, and it may attack almost any of the tissues of the body, as well as the lungs. A few months ago a young woman of twenty came to hospital complaining of pain in the neck from time to time, and of difficulty in swallowing. When we examined her throat, the appearance was quite extraordinary; indeed for a few moments it was difficult to realize what had happened. A large swelling in the back of the throat was bulging forward and almost completely blocking the whole passage. X-ray pictures of the neck immediately revealed the cause of the trouble. One of the lower bones in the neck had been destroyed by tuberculosis, and a large abscess had formed, and it was this that was blocking the throat. Surgical measures gave immediate relief of her symptoms, and systemic treatment with the new drugs soon did the rest. These few examples can give only a very slight impression of the extent of the misery and suffering caused by tuberculosis in India.

Reaffirming my firm conviction that it was in training nurses that Christian medical missions made their greatest contribution to medical work in India, I want now to consider one or two other fields in which medical missions have given an important lead. I use the words 'medical missions' rather than 'medical missionaries' because it is important to keep always before our minds the fact that Indian doctors and nurses as well as missionary doctors and nurses have been partners in the work.

Tuberculosis serves as a striking example of the contribution which Christian medical missions have been able to make in the fight against disease and human suffering, and in the cause of health, wholeness and the more abundant life which we believe is God's intention for men. It is a fine example of Christian co-operation; co-operation between Christian workers drawn from very varied churches and traditions; and it shows how much can be achieved when Indian doctors and doctors from other countries work loyally together. It is probably true that in the early days the first impulse came from doctors from abroad, but the greater part of the work has been done by Indian doctors.

The missionary doctors who preceded us in India in the early years of this century were well aware of the importance of tuberculosis, though in their day they can hardly have realized how big their task was. X-rays were not available on any considerable scale as an aid to diagnosis in their day; they would have to rely on their clinical skill and the use of the stethoscope. A teacher of clinical medicine remarked recently that the stethoscope has a place in the assessment of diseases of the chest, and that place is in the museum. There is just enough truth in the quip to press home a point. But those doctors were keenly aware of the need for a sanatorium to which they could send at least a few of the cases of tuberculosis that were crowding their hospitals. Doctor Louisa Hart of the Arcot Mission (Arcot is a district of the Madras State, and the mission working in it stems from the Dutch Reformed Church of America) was running a tiny sanatorium in the small provincial town of Madanapalle; and this must be regarded as the forerunner of the famous Union Mission Tuberculosis Sanatorium which is situated just outside Madanapalle.

A number of missionary doctors who were working in south India, and who were deeply concerned about the prevalence of this deadly disease in their midst, met together

to consider what they might do about it. They decided upon the establishment of a united missionary tuberculosis sanatorium. which was to be a co-operative effort, and to which a number of the missions working in the area would contribute. Their minds were directed to Madanapalle in the first instance because there was already a small sanatorium there. It was desirable that the sanatorium should be centrally situated in south India, and that it should be reasonably accessible. The Mysore plateau, which is between 2,500 and 3,000 feet above sea level offered the most favourable climate in south India. It was hoped that some government aid might be available, and it was more likely to issue from the then British Province of Madras than from the Indian Native State of Mysore. Madanapalle seemed best to meet all these requirements. It is on the eastern border of the Mysore plateau, 2,500 feet above sea level, and has a lovely climate, and was just within the borders of the Madras Province. It was then thought that a sanatorium should not be in the town for fear of spreading the disease. There was an area of almost untouched jungle, about four miles from Madanapalle itself which appeared to be a likely spot. Land was cheap, water was available, and it was sufficiently far from any considerable centre of population. A group of Christian doctors visited it, and there, in what was then virgin jungle, they knelt down, and together they tried to discover what was God's will, and if this was the place of His choosing. During the twenty-five years that I have been associated with the sanatorium as a member of its governing body and of its executive committee, I must have visited it on scores of occasions, and some of the workers there have been among my closest friends. But there can have been very few occasions when, as I have crossed the hilly crest which overlooks what is now known as Arogyavaram, or the Town of Health, and looked down upon the orderly roads and gardens and buildings lying below me I have failed to remember that group of Christian doctors kneeling in the scrub and among the rocks trying to learn what was God's will.

The Union Mission Tuberculosis Sanatorium was opened in 1915, and Dr. Christian Frimodt Muller of the Danish Mission was appointed as its first medical superintendent. He was a man of great ability and foresight, and determination, and, withall, a most devoted Christian. It could hardly have been possible to make a better choice. Now, looking back over the years, with some knowledge of what has been done there since those early days, I cannot help but believe that the prayers of the doctors were answered, and that God's will was done. In 1940 I was present at the silver jubilee celebrations of the sanatorium, and I well remember the words spoken by Major-General Wilson, Surgeon-General with the Government of Madras, on that occasion : 'I consider,' he said, 'that this institution is the peak of missionary endeavour in India.' This judgement is, of course, too sweeping for us to accept, but it was, at least, the estimate of a medical man, and one who had had long and wide experience of India.

When the sanatorium was opened it had only sixty beds, and it was not then clear as to how even that number were to be financed and provided for. When the number of beds reached one hundred it was thought that that must be the final limit, that we should never go beyond that figure. Today it has three times that number. Its popularity has always been a source of embarrassment to the sanatorium. As the number of beds increased its reputation grew still more rapidly, and the waiting list for admission grew longer and longer. Patients came from as far afield as Kashmir in the north, Bombay in the west, and Burma in the east.

In the more recent years, with the changing patterns of treatment, and increasing numbers of sanatoria in other parts of the country, this picture has altered. The pressure on expensive private wards is far less than it used to be, but the demand for beds in the general wards, where much of the treatment is free, is as great as ever. It may still take as long as six months to get a free bed in a general ward. In flippancy

mood I have often said that anyone who could survive the waiting list must do well after admission because they must have a good natural resistance to the disease.

From being a centre for the treatment of tuberculosis the sanatorium became a training school for doctors in this special field. Doctors who received their specialist training in tuberculosis at Arogyavaram are to be found occupying positions of responsibility in all parts of India, and they are the leaders in the fight against tuberculosis. Dr. C. Frimodt Muller was invited by the Government of India to become Medical Commissioner to the Tuberculosis Association of India. From this high office his experience became available to the whole country; and he was able to influence, and to some extent to direct, the anti-tuberculosis policies of all the provinces of India. When Dr. C. Frimodt Muller's health broke down, and he was forced to retire from active service, it was to our sanatorium that the Government again turned for help. Our first assistant, Dr. Benjamin, was invited to succeed him. It was with a good deal of reluctance, and not without many misgivings, that we acceded to the Government's request and released him for this important work. When the matter was under discussion, Dr. Benjamin said repeatedly that he was perfectly willing to go or to remain in the sanatorium, and that he would abide by whatever decision the Council would make. Since he has been tuberculosis adviser to the Government of India, Dr. Benjamin has become a figure of international stature in the world of tuberculosis.

In recent years Madanapalle has become increasingly a centre for research in tuberculosis work; and we have been most fortunate to have in Dr. Johannes Frimodt Muller, the son of our first medical superintendent, a doctor eminently qualified to take charge of, and to direct, the research work. To attempt to describe all that has been done would require a volume to itself, a volume that I should not be qualified to write. But the work has been of such interest, and such

importance, that to omit all reference to it would be to give an utterly incomplete picture. Dr. Johannes Frimodt Muller initiated, with the close co-operation of Dr. Benjamin, who by that time had gone to New Delhi, the Madanapalle Tuberculosis Control Scheme. This was an interesting experiment which had as its aim the prevention and control of pulmonary tuberculosis in a circumscribed rural and semi-rural area. Perhaps it would be more true to say that this was an attempt to see if such a thing could be done. It involved a very close house to house survey of the area which was being investigated, and it could not have been done without the willing co-operation of the people themselves, nor could it have been done by any institution that had not already won the confidence of the people. Indian village people would not easily submit themselves to tests and blood examinations, and mass radiography, and B.C.G. inoculations. It was no small tribute to the sanatorium doctors that the people were willing to put up with it all.

As the new drugs appeared for the treatment of tuberculosis, they have been submitted to controlled tests in our sanatorium to assess their value and their optimum dosage in Indian patients. It is wrong to assume that the disease follows the same pattern in India, as it does in the West. Indeed we know very well that it does not; and it is necessary to see how a new treatment can best be adapted to a different environment. All this has been a very important part of our work, and there are very few places in India where it could have been done.

It is perfectly obvious that sufficient sanatoria beds can never be provided to treat all the patients suffering from tuberculosis in India. Nor is it established that institutional treatment is necessary or even desirable in all cases. Field tests have therefore been started to try to determine the extent to which domiciliary treatment is practicable, and how effective it can be made. It remains to be seen whether it is at all

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possible by the use of new drugs to treat people for tuberculosis in their own homes. And these trials are still going on in and around Madanapalle.

In all this work our people have received encouragement and much financial help from the Central Government, and from the Tuberculosis Research Office of the World Health Organization. Without such aid the work would have been quite impossible, but without the men and the goodwill of the people it would be equally impossible. All this research has given us many new insights into the treatment and control of tuberculosis in Indian conditions. It would be quite impossible, as it is unnecessary, to attempt to describe the work in detail, but sufficient has been said to give some indication of the part that medical missions have played in this important work.

It must not be assumed that everything has been always plain sailing. Again and again we have been up against what looked like insuperable difficulties, and we have thought that it would be necessary to abandon, or at least to curtail, the work. There have been many vicissitudes, but time and again a way has appeared, often quite unexpectedly and the work has gone on.

XV

‘WITHOUT THE CAMP’

I WONDER what our feelings would be if one day we were told, quite unexpectedly; ‘You are suffering from leprosy’ or worse still—much worse—‘You are a leper’. You may reply that for most of us it is such a hypothetical question that it is not worth considering, and we may well thank God for that; but because it does not, and probably never will, touch us intimately, have we any right to say that is not worth considering? It is a very practical question for millions of people living in our world today.

Nobody knows, and nobody can know, how many people today are actually suffering from leprosy. The World Health Organization suggests that the figure may well lie between twelve million and fifteen million people. It almost sounds as though three million people more or less don’t matter very much. The Indian Census for 1931 gives the number of people suffering from leprosy in India as being round about 140,000. But Dr. Ernest Muir who was formerly a medical missionary in India, and a man who is likely to know as much about it as any living man, commented at the time that the figure might be multiplied by ten, and still be an underestimate of the actual situation.

There are a number of reasons for this uncertainty. It is almost impossible, in Indian village conditions, to collect any dependable data. The illiterate villager is only too anxious to be helpful, and is quite likely to give you the answer to any question which he thinks you would like to hear; or to give you any answer at all rather than appear to be unco-operative, or unwilling to assist you. You will often discover that when you are trying to find the way to some particular place. So it is unwise to place too much reliance on what you are told; and if you do, you may be in considerable danger of being misled.

But in inquiring about a disease like leprosy two other important considerations will influence the answers you receive.

The person may know, or at least suspect, that he has got the 'great disease', but be unwilling to disclose the fact; or he may be quite unaware of the fact that he has the disease. There are many stories of families who have kept a child shut up in a house, or even in a cupboard, for years rather than let it be known that one of their family has leprosy. Sometimes a child, or a young man, discovers almost by accident that he is suffering from leprosy. and when you have to break the news to him it is quite unexpected and comes to him as a tremendous shock. That is why the word unexpected was used in our opening question. The social stigma, and the psychological and spiritual damage which goes with it, may be far more dangerous than the disease itself. It is a disease which may, and often does, cause serious mental suffering which is largely due to ignorance on the part of the patient and wrong and very harmful attitudes on the part of the public. These are things which can and must be set right, and in which the ordinary layman can help. Generally it is not a painful disease; quite the reverse, it is often through failure to feel pain that the disease is revealed and recognized.

A few years ago a merchant, or perhaps I should say 'shopkeeper', in Chikballapur brought his son, a boy about twelve or thirteen years of age, to see me. 'Would you mind having a look at my boy?' he asked, 'He appears to have one or two pale coloured patches on his skin.' 'Very well,' I replied, 'let us take off his shirt and knickers, and we will have a good look at him in a really good light.' In most skin diseases it is wise to view as much of the skin as possible. So we removed his clothes and stood him in the sunlight. Then, standing back a little, I surveyed his whole body. Sure enough, there were three or four patches on his back, and a few on his front also. They varied in size, and were irregular in shape, and were rather paler in colour than the surrounding skin. They were, perhaps, a trifle raised, but not strikingly so; and it may be that they were a trifle more pink in colour; or that may have only been my imagination. I asked the nurse to bring me a pin and a cotton-wool swab; and I asked the boy to close his eyes

tightly; and then to tell me if he felt me touch him anywhere. Very lightly, with the cotton-wool swab, I touched his skin in one or two sensitive areas like the face and the forearms, so that he should understand what I was after. ‘Yes,’ he replied, and ‘yes’ again. ‘Where did you feel it?’ I asked. ‘On the cheek’, ‘On the chest’, ‘On the back of the neck’ came back the prompt replies. I went on, as before, touching sometimes the pale coloured areas, and sometimes the darker parts of the normal skin. When the pale areas were touched there was a hesitant, uncertain reply, or no reply at all. Then I tried the most insensitive areas with the pin. ‘Does that hurt you?’ I asked, ‘No’ was the answer. Sometimes he was aware of the pin prick, sometimes he did not feel it. But when the pin touched a normal area of the skin, he jumped briskly enough.

There was no need for any spoken word. My suspicions were aroused, but I was not willing immediately to commit myself. It was too serious a matter for the boy and for his family to make a mistake, or to give a rash opinion; too much was at stake. I could not be satisfied without an expert opinion. ‘Would you mind seeing another doctor — a very old friend of mine?’ I inquired. ‘I would like him to see the boy.’ The father must himself have been suspicious. He was quite willing to do anything, to go anywhere — however far. I sent him to see Dr. R. G. Cochrane, one of the foremost authorities in the world on leprosy. He was at the time, if I remember rightly, the principal of the Christian Medical College at Vellore. The father and the boy went there. The unhappy suspicion was confirmed, and the diagnosis was made. At Vellore he was treated with the utmost kindness, every possible reassurance was given, but the news fell on the family like a shattering blow. The boy appeared to be healthy enough, he was attending school, was intelligent above the average, was playing games with the other boys. Then all of a sudden, quite unexpectedly, this had happened. The family was tainted, their house might be infected, their friends would be afraid to go near them; and what of the shop and the business? It was all too cruel. How had the boy got the disease? When had he

contracted it? Nobody seemed able to answer these questions. Leprosy, so far as we knew, was very rare in Chikballapur. Nobody in their house, or in their family, so far as anybody knew, had ever had the disease. 'Has he been away anywhere?' 'Has he been staying away from home in another town or village for any length of time?' The answers were always negative, or they could not remember anything in particular.

We never did discover how the boy came by the disease. It is now generally held that in most cases of leprosy—especially in children—it is possible to trace the infection back to close contact with an infective case. But it is easy to fail to recognize in a particular case where the contact with an infective case of leprosy was made. Dr. Cochrane gives an interesting example as to how this might come about. A patient whom he had had under treatment was discharged as an 'arrested' case; and at the time of discharge was believed to be non-infective. But, to make assurance doubly sure, the man was given a certificate saying that he had been under treatment and was now believed to be cured, but also saying that he should only be given outdoor employment, and should not be given work as a servant in a house. Some years later Dr. Cochrane found the man working as an indoor servant in the home of a European family. On examination, it was discovered that the man had relapsed, and that he had again become an infective case of leprosy. There was a small child living in the house in which the man was working, and the child was in daily contact with the man. In this particular case the child never did contract leprosy. But suppose the child had returned to Europe, and then, some years later, had shown evidence of the disease, it might never have been suspected where the contact had been made. It would most likely have been assumed that the disease was due to some chance contact made in India—perhaps with the beggar who had come to the door, or some mendicant at a railway station—while in point of fact, though all unsuspecting, the child had been living in a house in which one of the servants was an infective case of leprosy.

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But the point I am anxious to make at the moment is related to the social consequences of the disease. A Christian boy I knew well was discovered, at the age of twenty, to be suffering from tuberculosis. When the unhappy truth was made known to him, instead of bemoaning his fate or even considering his own condition, he remarked in my hearing, and all in one sentence ‘I have let down the whole family. Who will now marry my sisters?’ Actually all his sisters have since been married; but had it been leprosy and not tuberculosis from which he was suffering, the consequences might well have been very different; he himself would probably have still been alive today; and even more probably, nobody would have married his sisters. The family might well have been ‘beyond the pale’. The Mission to Lepers have been no more than true to the facts of the situation when they took as the title of their magazine a text from the Bible—WITHOUT THE CAMP.

One or two of the misconceptions about this ancient scourge of mankind are still held today. It is impossible to give too much publicity to this matter, because it is ignorance that has led to so much unnecessary misery to countless millions of people. Never again must leprosy be thought of as some sort of taint—an uncleanness which places the sufferer ‘outside the camp’. Everything must be done to dispel the fear, the prejudice, and even the horror with which many educated and otherwise intelligent people regard leprosy. Recently I was talking to a highly cultured and experienced woman who is an almoner in a large hospital in Britain. Dealing with sick people was her daily vocation, so I was the more astonished to hear her say; ‘I only once saw a case of leprosy; and as I sat opposite the man I had a peculiar feeling—an uncanny feeling—amounting almost to horror—a feeling which I have never experienced about any other patient — even patients suffering from skin diseases which were far more disfiguring and far more repulsive to look at.’ I need hardly say I hastened to assure her, if that was necessary, that this peculiar feeling arose from something inside her, and not in the patient; and this she was perfectly ready to admit. It is this quite unjustifiable feeling of disgust that we must do everything we can to stamp out.

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Much confusion has arisen from a somewhat loose use of the word 'leprosy' in the Bible, particularly in the Authorized Version of the Old Testament. The disease which we call 'leprosy' in the modern world is a clearly defined entity which bears little resemblance to the disease or diseases which are described by that word in the Authorized Version.

The lesions of leprosy are not white, yet several times in the Old Testament leprosy is spoken of as though 'whiteness' was its most distinguishing feature. When the Lord commanded Moses to put his hand in his bosom, and when he took it out, 'behold his hand was leprous as snow' (Exodus chapter 4 verse 5); or again 'the leprosy therefore of Naaman shall cleave unto thee, and unto thy seed for ever. And he went out from his presence a leper as white as snow' (II Kings chapter 5 verse 27). On the other hand there is no suggestion anywhere in the Bible that leprosy is associated with loss of sensation which is almost the first thing we should look for today; it is the inability to feel pain or injury that is the real cause of the deformity, and gross ulceration, and mutilation and disfigurement which ordinary people have come to associate with leprosy, and which, in a few advanced cases, make it appear such a loathsome disease. It is not leprosy which causes ulcers but accidents which are not felt and are therefore neglected and go uncared for.

Leprosy is often regarded as a highly infectious disease. This is, at least, a gross exaggeration. Probably eighty per cent of the patients suffering from leprosy in India are not infective at all. Even so, that would still leave a quarter of a million cases in the country that are infective, and for these there are not more than 14,000 beds in institutions where they can be isolated. Today it is generally believed that to contract the disease, prolonged, intimate contact with an infective case is necessary; that means living in the same room with the patient for a long time, and, perhaps, sharing his bed or bedding or other household utensils. It is well known that young children are more susceptible to the disease than old people; and that it may take a long time to develop. For instance,

leprosy appearing in children between the ages of ten and fifteen, may well have been contracted in early childhood.

Leprosy is not a hereditary disease. The child born to parents suffering from leprosy has not got leprosy, nor will it get the disease if it is removed from its parents at an early age and kept separate from them.

The idea is gaining currency that all cases of leprosy can now be cured. This is definitely not so. It has been recognized for a very long time that in many patients the disease becomes arrested spontaneously, that is to say, the disease seems to die out of itself, and the patient may be said to be cured without any treatment at all. There are, on the other hand, cases that have undergone regular treatment for as long as twelve years, and from which leprosy bacilli have never completely disappeared. There are also cases which under treatment have shown very great improvement and apparent arrest of the disease.

The distribution of leprosy in south India varies a very great deal from place to place. Around Kowtalam leprosy is fairly common, whereas in and around Chikballapur it is relatively rare, but for the past four years a very considerable amount of unsuspected leprosy has been brought to light. At one time we had as many as ninety cases under regular treatment. This is a larger undertaking than you might imagine, because the treatment — though relatively simple — to be effective, must be regular and continuous. It consists, for the most part, in nothing more complicated than swallowing a few pills regularly every day; and keeping a check from time to time on the patient's blood picture. The difficulty arises from the fact that the patients are not all in one place, but are scattered about in a score of villages over a fairly wide area, and it is not always easy to make sure that each patient gets his or her supply of pills regularly. Actually, each patient's supply of pills, sufficient to last him for a week or a fortnight, is done up in a separate packet. Occasionally patients come to hospital to get their pills, but more often the packets are taken out by the

mobile dispensary every Wednesday. During the visits of the mobile dispensary the blood tests may also be carried out. This is a sphere of service in which a devoted layman can be of tremendous help. Simple though the treatment may appear to be, it must be carried out for long periods — for two years at least, and possibly five years, or even longer. Herein lies the chief difficulty. Human beings, whether educated or uneducated, are seldom as patient as all that. All of us know from experience how easy it is to forget to take one's pills, or to neglect any kind of treatment that has to be carried on for a long time. If there are signs of improvement, and if the symptoms subside a little, people become too easily satisfied, and are inclined to discontinue their treatment. If signs of improvement are slow in appearing, patients easily become discouraged and give up treatment prematurely. This is where a good deal of supervision and encouragement are necessary. But there is no doubt that most patients who will only stick to it, show very great improvement.

A few years ago an Indian doctor, who at the time was Director of Medical Services of the Government of India, gave the inaugural address at the Biennial Conference of the Christian Medical Association of India which was being held in Baroda. He had been speaking of the great contribution which had been made by Christian doctors to medical work in India, and then, in speaking of the work which had been done in the field of leprosy, he said something like this : 'Until comparatively recent years, practically all the work which was being done in India for the relief of people suffering from leprosy' was in the hands of Christian doctors.' Let me hasten to add that this is not the case today. Indian government doctors have now taken over a great part of this responsibility. But it was the missionary doctors who showed the way. In Dr. Cochrane's own words : 'One might say that all modern leprosy work was stimulated by Christian doctors. Of seven top ranking leprologists of the Anglo-American group, not less than five have been, or are, medical missionaries.'

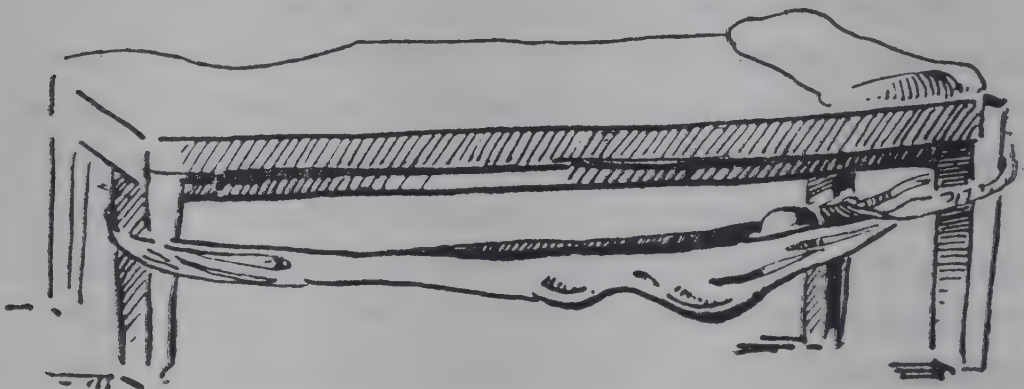
XVI

SUPERSTITIONS AND MANTRAMS

As I was going in at the hospital gate one evening, to do the night round, I was met by a man hurrying in the opposite direction. He stopped me, and in an agitated and excited tone of voice, told me that he must leave hospital at once. 'Oh ! What is the trouble ?' I inquired. He himself was not a patient, it was his wife who was the patient. 'There is an evil spirit in my ward,' he informed me. Now it was my turn to express surprise. 'Let us go and look for it ; or should I say "him" or "her" ? Because I've never seen it.'

We went right across the hospital compound to his ward, which was one of a pair of wards standing by themselves at a little distance from the main buildings on the far side of the hospital. He was by no means an unintelligent man, nor a poor one. He and his family were occupying one of the best private wards we have in the hospital. When we went into the ward his wife was in the bed, and there were one or two children and a baby in the room. 'Now, sit down quietly and tell me all about it,' I said. 'Where did you see this evil spirit? or if you didn't see it, tell me what it did.' 'It threw the baby out of its cot,' he replied. There was no cot to be seen, but I suppose there was no other word in Telugu to describe the contrivance he had made. 'What do you mean ?' I asked. He indicated a sort of bed sheet which was hanging under the patient's bed. One end of the sheet was tied to the head of the bed, and the other end to the foot—forming a sort of narrow hammock, which was slung under the bed. This was by no means an unusual arrangement, I had often seen it done before by patients. Indeed it is a most convenient device, because you can put the baby, or even bigger children, in the hammock ; then, if the child cries, you only have to put your hand out of bed, and give the hammock a little swing. There is no need to get up and out of bed ; an admirable idea for a harassed father. So the old-fashioned spring beds have some

advantage over the more modern box bed with interior spring mattress. Presumably the mother had been giving the baby a little swing, and it had fallen out on the floor. Of course I pointed out to the agitated father that, in the circumstances, such an accident might easily happen. 'But it happened more than once,' he persisted. 'Even that is quite possible,' I murmured in my most conciliatory manner. But he was not to be persuaded by anything that I could say. Whether there was more in it than he cared to divulge, I have no idea. 'Look here,' he said in a tone that indicated that he meant business, 'you can say what you like ; and you can make me a bill ; and you can make it as big as you like ; and I'm quite willing to pay it. But I won't stop in this room another night.' I have no doubt that he really was terrified, possessed by some sort of unreasoning terror. He did pay his bill, and he did pack up and leave that night. If this were just one isolated incident it would not be of any significance, but there is no doubt that the fear of evil spirits dogs the majority of Hindus from the cradle to the grave.



Child in hammock

Frequently, in going round the maternity ward, you may see on the top of a bedside locker, close to the mother's bed, a small collection of brilliant red chillies ; the shiny red pods on the glistening white enamel top of the locker make a striking picture. If you ask the woman why she has put them there, she will grin sheepishly and probably say nothing. The nurse will then tell you with a laugh, that they are to attract people's

attention, so that visitors and anyone who happens to pass by, will look at them, and not pay too much attention to the new baby. A new born baby is peculiarly susceptible to the influence of the 'evil eye', and the less people look at it the better. It is most unlucky to make too complimentary remarks about the baby ; because there is no more certain way of exciting the jealousy of some evil spirit that may be about, and which might do some injury to the baby. The moral is obvious. Do not be effusively polite, or too complimentary about every new baby you see. A woman also seems to be most vulnerable to these malign influences at the time of childbirth. In a village house, and occasionally in the hospital ward too, you will often see objects like a dustpan and a broom, or an old shoe lying close to a woman who is in process of being confined. They are there because they drive away evil spirits.

Superstitions of this kind do not die easily even among Christians. I remember once attending the Synod of the Church of South India ; the Synod, by the way, is the highest council of the Church of South India, and on it are representatives of all the dioceses of the Church. The wife of an Anglican bishop who was present at the meetings was frequently seen carrying round her first baby, of which she was justifiably a little proud. Such a thing might seem natural enough in Britain, and would probably go unnoticed, or at least it would cause no great comment ; but a number of Indian ladies who were there, were really shocked that a mother could take such unnecessary risks by exposing her baby to so much public admiration and receiving so many fulsome congratulations and compliments. It was regarded by nearly all the Indian women present as being most unlucky, and not very good form.

Death, not unnaturally perhaps, is surrounded by all kinds of fears and superstitions. Many of the evil spirits which haunt people, and which Hindus most fear, are spirits of the departed. Even the spirit of a much loved relative may have a malign influence soon after it is released from the body. For some days at least it will continue to haunt the house where it form-

erly lived, and may be a danger to the people living in the house; so that for some days, and possibly for months, it would be wiser to vacate the house. I have known a Brahmin family leave their house for as long as six months after a man died in it. It is not likely to be a thing I shall forget, because the man in question died in my arms.

A death in the hospital may give rise to considerable disturbance. We have at Chikballapur a line of private wards for men patients; there used to be five, but now, through the generosity of patients, there are eight rooms. On more than one occasion when a man has died in one of the wards, I have found that by evening all the wards would be empty. First one patient and then another would discover that he had some urgent family matter that required his attention, and that he must go home at once. Another said, 'Of course, I'm not afraid, but my women folk don't like it, and insist upon our leaving.' And yet another, who was more honest, said quite frankly, 'I'm scared stiff, and I'm going home.' In all countries the sight of a dead body produces a feeling of awe in most people; and everyone has a feeling of aversion to handling a dead body; but among Hindus there is no more certain cause of defilement than contact with a human corpse.

One of the chief preoccupations of an orthodox Hindu is to keep himself free from defilement—internal and external—and once having been defiled, all kinds of bathings and ceremonies and even austerities must be practised in order to get himself, or herself, purified and reinstated in society. Ceremonial defilement, of course, may have little or nothing to do with what we should regard as personal or physical cleanliness. Childbirth, for instance, places a woman outside the pale of decent society for ten or eleven days, or even for as long as a month. On the tenth or eleventh day after confinement, she has to have a ceremonial bathing, at which many of her more intimate lady friends are invited to assist, and only after this has been duly performed, can she resume her normal place in the household and carry on her normal domestic

duties—the most important of which is preparing and cooking the food for the family. One night I was called to the house of a highly educated Brahmin lawyer to see his new born baby. I took the baby in my arms and carried it over to the small oil lamp which was fixed to the wall, so that I could have a good look at it, and, after a few minutes, because I wanted to go in and see the mother who was in another room, I turned round and held out the baby for the father to hold. If I had trodden on his toe he could not have jumped back with greater alacrity. The touch of his own baby would have defiled him. He could touch neither his wife nor his baby till the ceremonies of purification had been duly completed on the eleventh day after the baby's birth. Was this because he was an ignorant villager? By no means. He was, as I have said, not only a highly educated and cultured man—a double graduate with a degree in arts and another in law—but also a political leader.

The mere presence, or even the shadow, of a 'harijan' (a person belonging to the depressed classes) may cause defilement. An orthodox Brahmin woman was a patient in one of our private wards. Adjoining the ward was the usual small private kitchen. The woman was suffering from a peculiarly disagreeable disease—to put it no more strongly than that. And the kitchen, in our view, had become highly contaminated; there were faecal droppings all over the place. The nursing superintendent sent one of the hospital 'sweepers' into the kitchen to clean it up. In doing this, and not realizing the enormity of the offence, she had dropped, what in the new idiom might be called a not inconsiderable 'clanger'. Next time the nursing superintendent visited the ward, she was confronted by an extremely indignant patient. 'What do you mean by sending that man into my kitchen?' demanded the irate woman. 'How do you suppose I shall ever be able to cook in the room again?' she continued. Nothing that the patient herself could do to the room could pollute it, however disgusting it might appear to some of us—but the presence of such a man, even to clean up the place, was enough to render the room quite

unsuitable as a place to cook in. It should be a humbling thought for those of us who are Europeans, that in the view of Hindu orthodoxy we are in the same class as other 'untouchables'. The same nursing superintendent, who was ever ready to lend a hand to anyone who seemed to need it, one day noticed an old woman struggling across the hospital compound with a heavy earthenware water-pot on her hip. She was an old Brahmin woman who was carrying water from a tap to a relative in one of the wards, and she seemed to be having some trouble with the pot, so the nursing superintendent went to give her a hand with it. As soon as she touched the water-pot, the old woman immediately threw it on the ground. The pot broke to pieces, and the water ran all over the ground; but, so far as the old woman was concerned, once the earthenware pot had been touched by the hand of a European it could no longer be used, nor the water that was in it.

'But,' you may object, 'those days are gone. The India which you are describing no longer exists. Caste has been outlawed by act of parliament.' Are you quite sure of that? One of our L.M.S. nursing sisters once advised a patient she was examining to go to hospital. 'I could not do that,' the man replied, 'my caste would be spoiled.' 'Don't you realize that there is no caste in India today?' the missionary rejoined. 'Caste and untouchability have been abolished by law. Hasn't Mr. Nehru said so repeatedly?' The villager looked up into her face, and with a naive smile inquired, 'And what does he know about it?' Which reminds me of the reply given to me by another villager in similar circumstances—though it is not easy to reproduce the exact feeling of the Telugu idiom he used: 'That method of reckoning may be all right in New Delhi, but not in this village.' Always we must remember that in India eight out of every ten of her people are villagers. Centuries of poverty, illiteracy, ignorance, superstition and custom cannot be swept away overnight.

Side by side with these superstitions and fears we find in India some of the most highly refined systems of philosophy,

but these are of little avail to the ordinary man, the man in the street. The cultured and philosophic Brahmin would contend, and not without reason, that it would be ridiculous to try to inculcate into the vulgar and uneducated herd these elevated philosophical conceptions. For the sake of the common man and his wife, to deliver them from their superstitions and fears, and from the bondage of the innumerable evil spirits that constantly beset them from birth to death, there has grown up a complex system of charms and amulets, and *mantrams*. Perhaps 'system' is not the right word, because there is little that is systematic about these things. Actually they cannot protect the man from the evil influences that surround him, nor can they do much to relieve him of his fears, they only add to the total of superstition ; and confusion is worse confounded.

Most of the patients who come to hospital, and especially the children, wear round their necks, or have tied to their arms some sort of charm or *mantram*. A *mantram* is essentially a prayer ; but it has come to mean a particular form of words, a formula, an incantation which has great magical power to drive off—exorcise—evil spirits ; or to cure a man from his sickness. Often these two amount to the same thing, because it is an evil spirit—a *daiyamu*—which is the cause of the sickness. Some *mantrams* are believed to be stronger than others, and the power is inherent in the actual wording. To be effective they must be recited with scrupulous care, and attention must be paid to correct pronunciation. To make a mistake may be a serious matter ; the power might rebound on the head of the person who had made the mistake, and do him some injury. I regret to say that I have known Christians, even members of our own church, who have called in a Hindu neighbour to drive away an evil spirit which they believed was troubling them. When I made some inquiries about the whole incident, which I must not here stop to relate, I was told 'Oh ! but he knows some very powerful *mantrams*'. The *mantrams* may also be written down either once or repeated many times over, and the paper tied up, as it were in a little scroll, and

the scroll then put into a little metal cylinder and tied to the arm. I have before me now, as I write, a *mantram* written in hospital nearly ten years ago. The words are written in very small Telugu letters in scrupulously arranged columns, 3,655 times on the two sides of a single sheet of foolscap paper. In this case the words are very simple, just one name of god : 'Sri Rama Sri Rama . . .' it goes over and over again—3,655 times. The number is entered at the bottom, and the sheet signed with the patient's name.

There are *mantrams* which are appropriate to all the vicissitudes and accidents which may befall us in life, as well as for births and marriages and deaths. Some are supposed to be effective in curing diseases—and he would be a poor doctor, and sadly lacking in a proper understanding of his art, if he prescribed or administered his medicine without reciting the appropriate *mantram*. Things not very unlike that still happen in this country today. At one time the recitation of these powerful incantations was the prerogative of one caste only—the Brahmins—but this is no longer the case today. There is an old saying that runs something like this : 'The universe is subject to the gods, the gods are subject to the *mantrams*; the *mantrams* are subject to the Brahmins; therefore the Brahmins are your gods.' The times are changing all that ; the Brahmins have lost much of their authority, but fear and superstition do not die so easily.

This can only be a brief and very inadequate account of the superstitions which bedevil the lives of multitudes of people in India. But some mention of them is essential because these ideas form an important part of the mental background of many of the patients who come to our hospitals ; and we come up against them in our medical work every day of our lives. Have Christian medical workers any important or special word to say to these people ? The opponents of Jesus did not deny His power to cast out devils ; but they were concerned to discredit His power. 'And the scribes which came down from Jerusalem said, He hath Beelzebub, and, By the prince of the devils

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casteth he out the devils.' (Mark 3:22.) Jesus goes on to clinch His argument, 'No man can enter into a strong man's house, and spoil his goods, except he will first bind the strong man ; and then he will spoil his house.' If a strong man is to be overcome, only a stronger man can do it. If the captives of a tyrant are to be rescued, the tyrant must first be overcome by a still stronger man.



Brahmin woman

XVII

THANK YOUR LUCKY STARS

*Men at some time are masters of their fates;
The fault, dear Brutus, is not in our stars,
But in ourselves, that we are underlings.*

THESE words, which Shakespeare puts into the mouth of Cassius, are familiar to every schoolboy in England. Or are they? I don't know if Shakespeare is studied as closely as he was when I was at school. But probably most English schoolboys would accept the thought contained in these lines. In India, I should think, it is far otherwise. Moreover, I find it hard to believe that it was a very generally accepted idea in the days of Julius Caesar either. Cassius must have been a man before his time; and India has hardly caught up with him yet. Astrology must at all times have exercised some influence over the nations of the world, civilized as well as uncivilized; and the idea that the stars may exert some influence upon the earth, and upon the men and the animals and the plants that inhabit it, need not necessarily be utterly wild and hysterical. Everyone will acknowledge that there is a great deal more in this world of ours than we know, or can understand. But nowhere else in the modern world can astrology have been carried to such extremes as in India. I often think it is difficult to understand how it has become interwoven with other Hindu philosophical doctrines with which it would seem to have little, or nothing, in common.

The fear of spirits, particularly evil spirits, is general in India; and certain manners and customs have an important bearing upon our medical work and deeply influence the attitude of people to health and to disease. But not less important is the influence of astrology, and the excesses to which it has lead. For many people life seems to be very largely governed by lucky and unlucky, auspicious and inauspicious, times and seasons.

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New-moon days and full-moon days are days of fasting, and are uniformly regarded as unlucky days. Nobody would embark on any new or important enterprise on one of these days. Sunday, Tuesday and Saturday are not good days either. Tuesday used to be one of the days of the week we kept as an operation day. It was really not a very good choice, because I was often told by people that they would prefer to have their operation done on some other day. One and a half hours of every day—the so called *rahu kala*—is a very unlucky time. Many people would not want to be admitted to hospital, or to be discharged, or at any rate to leave hospital, during that time. Frequently patients ask that their operation may be postponed till the *rahu kala* is passed, or to get it done before it begins. It is not any one fixed time, but changes from day to day like the tides of the sea. You couldn't possibly start a new or important piece of work during that period. You certainly ought not to go to hospital, or to leave hospital, unless the day is favourable. Many a time patients who were not getting well as quickly as they thought they should be, have said to me that it was due to the fact that they had entered hospital on an unlucky day. 'Please will you discharge me now, and I will certainly return at a more propitious time,' they say. No blame is attached to the doctor, it is just that the time was unfavourable,

Not only must you select an auspicious day, but the hour, and even the exact moment may be important. Some years ago the Uvaraja—he was the cousin, I think, of the then ruling Maharaja of Mysore—came to inaugurate the installation of the government electrical current in Chikballapur. It was a terrific occasion. The streets were swept and cleaned, the houses decorated, triumphal arches were built across the roads, and so on and so on. We were all invited to attend the ceremony. Europeans were expected to wear morning clothes with tail coats; and it was a particularly stuffy afternoon in the hottest part of the year—so it was not a very 'lucky' day for us. All members of the municipal council and all government officers had to wear 'court dress'. This consisted of long black

frock coats with a white sash round the waist; and some sort of white nether garments, either 'drain-pipe' trousers—such as are affected by Mr. Nehru in all current pictures of him—or a white *dhoti* or *pancha*. Outside the municipal boundary a large marquee was erected, where the Uvaraja was to rest until the auspicious moment arrived. Only then could he enter the town.

But how does one discover what is the precise moment at which a ceremony should be performed? The precise moment is of very special importance in marriages. You must consult the *prohita* or family priest. It is his business to know about such things. He may have to consult a still more highly specialized *prohita*; but if he himself is sufficiently skilled in these matters he may turn directly to the *panchangam*, that is the Hindu calender, and from the data contained in it, make the necessary calculations. The *panchangam* is a supremely important publication. A Hindu *purchita* could no more dispense with that than a ship's captain would set sail without a compass and a nautical almanac. As its name *panch* . . . indicates, it deals with five subjects: the age of the moon in the month; the constellations near which the moon is situated on each particular day; the day of the week; the times of eclipses; and the positions of the planets. The movements and the conjugations of these celestial bodies profoundly influence the destinies of mortal men. Some planets exert a good, and some a bad influence. When good and bad coincide, each cancels out the effect of the other; and when two good or two bad coincide each reinforces the influence of the other. You must choose your time accordingly. But there are events in life the exact timing of which you can neither choose nor foretell; for instance the precise moment of your birth; is there anything you can do about that? A few examples will help us to see what actually is done.

A wealthy man, a landlord who owned large properties in our district, came to me one day with a new clock in his hands. His wife was a patient in the hospital waiting to have a baby. He said he wanted me to take the clock and keep it in the labour room where the baby was to be born. 'Please make a

careful note of the exact time, by this clock, at which the baby is born,' he said. He had bought the clock especially for this purpose and had taken it round to the electric office, where he had ascertained the correct time, and had set the clock accordingly. It was of the great importance for the child's horoscope to know the exact time, down to the nearest minute, at which the baby was born. The state of the heavens, the positions of the heavenly bodies, the moon, the planets and the stars at the moment of birth, these to a large extent would determine the fate and the future progress of the baby. We did as he asked, and when he knew the exact time at which the baby was born, he took the information to his family *prohita* for the necessary computations to be made. I was told that the sum he paid to the *prohita* for his services was twenty times the amount he paid to the hospital for looking after his wife and the baby. One might think that he wanted the horoscope to be made as favourable as possible. I'm afraid it was of little avail, because the little girl—it was a girl—that was born then, died of diphtheria before she reached her 'teens.

No ! horoscopes don't always turn out to be true. We had a boy of twelve or thirteen in hospital once, who was suffering from advanced rheumatic disease of the heart. He had been with us a few weeks before, suffering from all the signs of heart failure; but when his symptoms were relieved he had been taken home. Now he was in hospital again with the same symptoms; and he was not doing so well. I was sitting in my study one afternoon when the boy's father came to see me. I think he did realize how ill the boy was, but he could not bring himself to accept it — probably few of us could. 'We would like to take the boy down to the Christian Medical College at Vellore to see one of the big doctors there,' he said, 'and we should like you to go down there with us.'

It is about one hundred and thirty miles from Chikballapur to Vellore. I didn't really feel that I could spare the time; and I was by no means sure that the boy would be able to stand the journey; and I told the father so. But he was not to be persuaded.

'I have consulted my *prohita*,' he continued, 'and he assures me that tomorrow is a very auspicious day for the journey. We will take the hospital car, and go in it from door to door. It will be very easy. It is clear from the boy's horoscope that he is to have a severe illness, but that he will recover from it. He will live to be fifty-five, and will become a leading man in this town.' I'm not sure that he didn't say that the boy was destined to become president of the municipality.

'Well,' I said, 'if this is all fixed, why should we bother ourselves any more about it? Would it not be better just to let events take their course?'

'Ah!' he replied, 'but God expects us to do what is our duty also.'

I could not very well quarrel with that theology; so I agreed to his proposal that we should go the following morning. The hospital car was an old Ford 'V 8' station wagon. The boy's father, our car driver, and I sat in the front seat. The boy was packed in between three or four women in the next row. Some children and a large collection of bedding and cooking utensils occupied the luggage compartment at the back. We set out at the hour appointed by the *prohita*. As the car moved out through the hospital gate, a number of the patient's relatives broke coconuts by throwing them down with much violence on the road in front of the car. This was a sort of valedictory prayer, a supplication for journeying mercies, and a successful outcome to our enterprise. Modern Hindu exegetists would explain that the broken coconuts symbolize the broken heart offered to God and laid open before Him. Where they learned such a method of exposition it is not difficult to guess.

At a place called Mulbagal, on the border of the Mysore State, we stopped to fortify ourselves with coffee at a wayside coffee shop. A little further on we stopped again in the shade of some big trees on a river bank to eat our midday food. I shared the *chitranna*—a sort of rice preparation—which the people had brought with them; and very good it was. The

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patient was left lying in the car, while we picnicked by the river. He seemed to be bearing up well, and we were a cheerful, confident party. Soon after four o'clock in the afternoon we reached Vellore. At the Christian Medical College Hospital Out-patients department we were informed that the great physician we had come to see was not at Vellore. He had gone to Madras in connection with some university business, but was expected back that night. With a good deal of difficulty, and not without considerable rearrangements of beds, we got a place for the boy in the hospital. I arranged with one of the resident house physicians for a consultation with the great man at nine o'clock the following morning. The women and children found some accommodation in a neighbouring Hindu hotel; and I went off to spend the night with our London Missionary Society doctor, Howard Somervell, and his wife. About four o'clock the next morning I was called by the car driver. A message had just been received from the hospital saying that the boy had died; the relatives were wailing and disturbing the other patients; please would I go down to the hospital at once. I dressed and went down immediately. The message I had received was perfectly true; the noise they were making was considerable. There was little that I could do, so we prepared to return to Chikballapur. We laid the boy's body in the car, and the women arranged themselves round it as best they could. The terrified children wept, and the women wailed every yard of the one hundred and thirty miles back to Chikballapur. The father sat next to me—utterly crushed by the terrible blow—and did not make a sound. It is a pathetic little story. Perhaps the stricken man was able to draw some consolation from the thought that he had done everything that he could. The incident did not destroy our friendship with that family, indeed it may have strengthened it. Only a few months ago the man brought his own brother to me for an operation.

One more small incident will make still more clear how deeply ingrained these superstitions are in the thinking of the people. Very early one morning I received a message asking

for the car to be sent to a house in the town to collect a small boy, who was suffering from typhoid fever. 'The car must be at the house before seven o'clock,' I was told, 'because the *rahu kala* (the unlucky period) starts at seven.' The car was there by six thirty—allowing plenty of time to get the small boy to hospital before the inauspicious hour should arrive. The patient was carried out of the house and put in the car. We were all set to go and then—the car would not start. It was an ancient chariot, which had served us for nearly ten years, and it was not new when we bought it, and it had its little eccentricities. The driver got out, and tried with the starting handle, but without effect; he raised the bonnet and fiddled with this and that, but his efforts were of no avail. A few spectators who were standing round gave us a push, but when they stopped, the car also stopped. The hands of the clock moved inexorably forward—only the car remained unmoving and unmoved. Seven o'clock and the unlucky moment was fast approaching; what was to be done? A few minutes to the hour the father insisted that the patient be removed from the car and returned to the house, and this was done. A few minutes later the engine consented to fire. But then it was too late. The *rahu kala* had begun. We were told that we must return in the evening, when the time would be more favourable. This was done, and the boy was eventually brought to hospital, and he made a good recovery.

What does this incident show? That the father was uncivilized, an uneducated man? No, he was a peculiarly cultivated person, and a graduate of two universities. It shows that there are depths in the Eastern mind that the highest Western education cannot touch.

Many of us in this country would do well to thank God, and not our lucky stars; and to remember that, whether we recognize it or not, and whether we acknowledge it or not, we were born under the star of Bethlehem, and all that has flowed from it during these last two thousand years.

XVIII

THE MISSIONARY OUTLOOK

IN Western countries it is now generally recognized that the health of the people is part of the responsibility of government, and in most countries government accepts that responsibility. But even so there may still be in those countries a place for Christian medical work, apart from what is sometimes spoken of as 'divine healing'.

In India, too, the Government recognizes its responsibility for the health of the people, and schemes for promoting public health and providing increased medical aid occupied a large and important place in the first two Five Years' Plans which are just now being concluded, and in the Third Five Years' Plan which is about to be launched. But in India the task is so vast, and the need so great, that there is still plenty of room for work by private agencies as well. In this situation Christians have a special opportunity, and also a special contribution to make. At the present time there are two particular directions in which Christian medical workers should give a lead. First, they should set an example of willingness to work in those difficult rural areas where the need is greatest.

Thirty years ago when my wife and I were preparing to go to India, we had a conversation with Dr. Ernest Muir, who was just coming to the end of a long and distinguished career in India. He was a man who first went to India as a medical missionary, and later joined the Government Medical Service, and became principal of the School of Tropical Medicines in Calcutta. For a time he was president of the Indian Christian Medical Association, and he had a wide experience of India's medical needs. He was urging upon us the distress in rural areas, and the need for medicine in country places. In my ignorance I ventured to suggest, 'But surely this is the Government's responsibility.' 'Yes,' he answered, 'but it is exactly the work that Government finds it most difficult to do, because it cannot get doctors to go and live and work in such places.' For at least a generation the Government of India—both the

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former British Government and the present Indian Government —have been acutely alive to the needs of the rural areas, but have been unable to get medical workers to serve in country places. All kinds of proposals have been put forward with a view to solving this difficulty. For instance, it has been suggested that because the cost of medical education is largely met out of public funds, the public has a right to demand that all doctors trained in government medical colleges should give two or more years' service in rural areas. The fees paid by medical students cover only a very small proportion of the cost of their training; and it was perfectly reasonable that for a time at least they should be made to work where the Government should ordain. Actually little has so far been done in this direction.

Exactly what are the difficulties of working in a backward, underdeveloped, country place? First of all, such places are generally very inaccessible and communications are bad. They may be miles from a railway, or even from any good road. Then there is the loneliness a man feels who has been educated and brought up in a town or city. Entertainments are few, and there is for him little or no congenial society. Professionally too, the doctor is lonely, because there is nobody to whom he can turn for advice or for help. He must very largely depend upon his own resources and upon himself. Constantly demands are made upon him which are beyond his resources and beyond the scope of the meagre equipment with which he is provided. Then there is the problem of where the doctor is to live. Only in rare instances are quarters provided for him and his family. Generally he has to find what accommodation he can in the village, and as often as not, no house is available. The doctor's wife may feel as lonely as he does, there is little if any companionship for her; and she may well ask, 'Where are the children to go to school? What is to become of their education?'

Quite recently a new 'Combined Dispensary' (serving men and women patients) was opened in Chikballapur by the Government. It was to replace the two separate dispensaries which have been in existence for many years. Besides the dispensary, accommodation was provided for twenty beds.

The cost of the new building was about £ 7,500. A further £ 400 was spent to enclose the building with a wall ; but not a single new piece of equipment was provided, nor a single nurse, and not even one bed. The people of the town and neighbourhood have been in no way benefited by this new venture. All this in Chikballapur, which is an urban, and not a rural area. Not long ago there was a strike among nurses in the Bombay Province because some nurses had been asked to serve in certain rural areas. When their grievances were investigated, their reply was perfectly simple : 'We are willing to go, if satisfactory provision is made for us to live and do our work.' In nearly all country places water supply is difficult, food is difficult to get, and sanitation is non-existent. It is not surprising that doctors and nurses who have not been accustomed to village life are not willing to go and live and work in such an environment. But it is exactly because conditions are hard that the Christians have an opportunity to give a lead. What is needed is 'the missionary outlook.'

Secondly Christians might set an example as to how medical work should be done, and medical needs met. To meet the medical needs of the country is obviously beyond the resources of the Christian Church ; and the costs of modern medicine are mounting year by year. Nevertheless on a limited scale, and by concentration on one or two selected places, it might be possible to give a demonstration of what can be done. The Union Mission Tuberculosis Sanatorium at Madanapalle, about which a good deal has been written elsewhere in these pages, served for many years as a model of how tuberculosis work could, and should, be done. When Lady Linlithgow, the Vicereine, opened the sanatorium in Kassuli—the sanatorium which bears her name—the best that she could wish for it was 'that it should be like the mission sanatorium at Madanapalle'. And it was a Christian doctor from Madanapalle who was selected to be its first medical superintendent. But such a thing may only be possible through co-operative effort ; and it may require some existing pieces of work to be curtailed, or even closed. After all, Jesus did remind us that to acquire the

pearl of supreme worth, the merchant who dealt in those things and knew their value, had to sacrifice his entire stock.

There is one other thing that Indians value, and which Christians ought to be able to offer, and in which they should be able to set an example—something which is quite intangible, but very real and easily recognized. Some years ago I was attending a Mysore State Medical Conference, a conference very largely organized by the State Medical Department, but not exclusively for government doctors. They did, in fact, once do me the great honour of asking me to preside over the surgical section of the conference. But in the particular year that I have in mind, I was almost the only medical missionary present, and I was astonished at the number of references made by different speakers to Christian medical mission institutions. The opening address of the conference was given by the Minister of Public Health and Local Self Government. In the course of his address he informed the doctors present, nearly all of whom were Hindus, apart from a few Mohammedans, that they should be more 'missionary in their outlook'. Exactly what he meant was not clear. He cannot have meant that they should embark upon a campaign of Christian evangelism, as he himself was a Hindu of fairly high caste. Apparently this odd remark aroused some comment, because when speaking at the dinner in the evening, he returned to the subject. 'This morning, when I said you should be more missionary in your outlook, I did not mean to suggest that you were not conscientious and sympathetic in your work. Still, I think you should be more missionary.' That did not appear to add much to what he had already said, or to make his meaning clearer. He was obviously trying to say something, but was unable to get beyond the word 'missionary' to describe whatever it was he had in mind. It is that 'something' which Christian institutions should be able to provide. Perhaps the word 'caring' might describe it. Intangible? Yes, but easy to recognize. Kindness is not enough. What is needed is understanding and concern—and I suspect that that is what the Minister for Public Health had in mind when he suddenly fastened upon the phrase 'the missionary outlook'.

XIX

CHIKBALLAPUR AND KOWTALAM

THE medical missionary experiences recorded in these pages are largely centred round two places, Chikballapur and Kowtalam. Chikballapur is the mother hospital, where we have one hundred and ten beds, and Kowtalam, the daughter, has at present only about thirty. They are rather more than two hundred miles apart, and serve quite different areas, though the majority of the patients in both hospitals are village people. Chikballapur is thirty-five miles by road from Bangalore, and Kowtalam some seventy miles from Bellary. Both Bangalore and Bellary have been head stations of the London Mission for more than one hundred and fifty years, and both were included in what was known as the Kanarese field. In 1960, the Bruce Petta Church in Bellary celebrated its triple jubilee — evidence, if that were needed, of how early the Free churches came to recognize their missionary responsibility.

The work in Bellary and Bangalore had little in common apart from the use of the Kanarese language; and by no means everybody in either of these places speaks Kanarese. Bangalore is a cosmopolitan city in which many languages can be heard; but in so far as it is the seat of the Mysore Government, Kanarese is the official language. Until quite recently, half the people in Bellary spoke Telugu rather than Kanarese, and in the days of the British, Bellary was classed as a Telugu area. Now that it is included in the Mysore State, Kanarese is the official language there also. *The Churchman's Diary* for 1960 indicates that about one and a half million people regard Kanarese as their mother tongue, but the great majority of them speak at least one other language as well. In the north of the Mysore State it is mixed with Marathi; in the south, near the Nilgiris, with Tamil; in the east, where Chikballapur is situated, with Telugu; and on the west coast of India with Konkani and Tulu and even Malayalam. Perhaps one should say it with bated breath, but actually, Kanarese is one of the smaller languages

of south India, because nearly thirty-three million people speak Telugu, and seventy-six and a half million speak Tamil. I have not mentioned Urdu, which is the home language of all Mohammedans, who constitute ten to twenty per cent of the entire population of the Indian peninsula. And it was the official language of the old Hyderabad State, which was the largest so-called Indian Native State. Even Kanarese varies a great deal from place to place. An outsider would hardly recognize it as the same language. In Kowtalam, for instance, the most commonly used word for 'pain' is *bene*, but if you were to ask any patient in Chikballapur if he had a *bene*, he would not have the least idea what you were talking about. All this discussion about language is something of a digression, but it is worth mentioning because language has become politically significant in India today; it divides people very deeply, and it is a measure of the diversity of the peoples of India.

In each of the main language areas in south India in which the London Mission has work, the mission had a fairly large hospital. Jammalamadugu stands near the centre of the London Mission Telugu area; while Erode is well situated to serve our work in the Tamil field. Chikballapur, it has already been noted, is near to Bangalore, but is much too far away from Bellary to give much help to the work in that district. In that part of south India which used to be called Travancore, but which is now called Kerala and the Kanyakumari district of the Madras State, the L.M.S. had numerous hospitals. The famous Neyyoor hospital serves the south of the area, while Kundara, which was originally a branch of the Neyyoor hospital, but which is now as large as any of the L.M.S. hospitals in south India, apart from its parent hospital at Neyyoor, serves the north. Only the mission in the Bellary area had no medical arm.

In 1939 I was on furlough, but at its meeting in June of that year the Kanarese Committee of the L.M.S. passed a resolution asking that, as soon as possible after my return to

India, I should visit the Kowtalam area along with Miss Madge Barrett, the Rev. C. B. Firth, and the Rev. S. Sundara Raja. The latter was an experienced Indian pastor, who was then in charge of the church in Adoni. All three of them knew the district well. The purpose of the visit was to make a study of the medical needs of the area, and to make proposals as to what might be done towards meeting them.

On a warm, sunny morning in the first week of February 1940, we set out from Bellary, travelling in the Ford V8 station wagon which belonged to the Chikka hospital. Sam, the hospital car driver, Cyril Firth and I occupied front seat, while Miss Barrett, the Rev. Sundara Raja, with David the cook sat in the second row packed round with water bottles, hurricane lanterns and other camp equipment. The rear compartment was crammed from floor to roof with bedding and personal baggage. Fortunately for us, Indians can travel much more lightly than most missionaries can. A small bedding roll and a spare shirt or two suffice to meet their needs. No woollen clothing was necessary for any of us.

Fifty miles from Bellary we stopped for a few minutes in Adoni, a busy cosmopolitan market town with a population of about fifty thousand people. Adoni is on the main railway line between Bombay and Madras, and is about midway between those two great cities. It is not a very pleasant place to live in, being hot and dusty and smelly and full of flies. Perhaps it is rather better now than it was in those days. But, if you have any doubt about it, you may still visit the meat market on a hot afternoon, and be left wondering how so many flies can make a living in one place. For all that, Adoni is an important commercial centre. Merchants from Bombay and from Gujerat congregate there to buy cotton and ground nuts and other commodities. In the town there are two small government hospitals with fifteen to twenty beds in each—one for men and one for women, but these hardly suffice for the needs of such a big town. There are, of course, also a number of private

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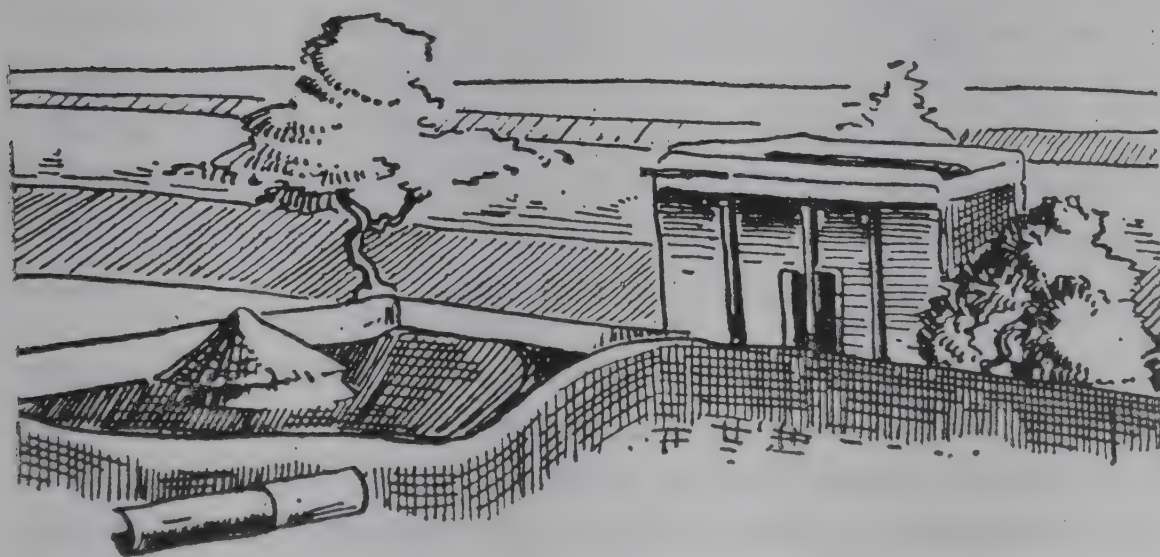
practitioners of medicine, as there are in most towns of any size, but they can do little to help people in rural areas. Private practitioners must of necessity adhere fairly closely to the well-beaten trade routes.

From Adoni to Kowtalam is another twenty miles, and we stopped in Kowtalam for an hour or two and had our midday meal with the pastor there. Now we really were out in the country. Main roads had been left behind. The hot, dry cotton soil stretched to the horizon on three sides of me; only behind us was the horizon broken by a line of very ragged rocky hills. Apart from the late season cotton, which was still waiting to be picked, there was little vegetation. Other crops like corra, cholum and groundnuts had long since been harvested. Between Adoni and Kowtalam you pass only through two villages; one called Kupagal, which means a heap of stones, and another called Herigeri which looks like Kupagal. We were making for the village of Hotcholli, which is ten miles beyond Kowtalam. The road had now degenerated into a rutted cart track bestrewn with boulders. Sam was becoming anxious for the safety of his car; but there was worse to come. Before reaching Hotcholli, two river beds have to be crossed. Over the first of these the road ends on a bridge which spans just half the river. But that makes no sense. Exactly—it makes no sense at all. The bridge juts out from one bank of the river like a pier, and in midstream the bridge, and the road with it, comes to an abrupt end. The other half of the bridge must wait till the next Five Years' Plan or some still more distant date. There is no 'A.A.' to mark the diversion. An unwary driver might well break his neck; the more cautious driver will just follow the cart tracks down the bank, across the sandy bed of the river, and up the opposite bank.

Near the second river is the village of Muruvani, where there is a Christian congregation, the oldest congregation in the district, now rather more than sixty years old. In 1940 we used to have a school there, with a village boarding home for

boys. This was under the care of a very experienced headmaster—Mr. Revanna. In anticipation of our visit he had mustered his small boys to do some emergency repairs to the road. The river banks are terrifyingly steep at that point, and but for his forethought, the car might never have got any further. The cleft in the river bank, which served as a road for bullock carts, was not altogether suitable for a Ford car. It had to be made wider, and much less steeply sloping. Mr. Revanna had attended to all that before we arrived. But even so the passage across the river was not devoid of excitement, and it consumed a good deal more petrol than we could really afford.

That night, and for the three following nights, we camped in a ploughed field on the bank of the Tungabhadra river, about one mile outside the village of Hotcholli. As the Tungabhadra river is formed by the confluence of two rivers, the Tunga and the Bhadra, both of which take their rise in the highlands to the west of the Mysore State, there is water in the river at all seasons of the year. This was most convenient for us, as there was no shortage of water to drink, and I was able to bathe in the river every morning despite a scare of crocodiles — I must say I never saw one. After four



Tungabhadra river
seen from pastor's house

nights there we moved on to Halve, which is also near the Tungabhadra river, but ten miles further to the east. There also we camped for three nights. From those two centres we made excursions every day to a number of different villages.

All the villages in the area look much alike, being built of local stone and the dark grey soil of the surrounding country. In the hot weather, when all the fields are bare of crops, the villages merge with the landscape from which they have been dug. They are compact, and some of them resemble nothing so much as great grey battleships floating on a grey and dreary ocean. The grey earthenware drain pipes which stick out at right angles from the roofs of the houses look like gun barrels, which adds to the illusion.

At that time there were fourteen organized Christian congregations in the area, with a few families scattered about in other villages. For the most part we confined our attention to the places where there were congregations, or where work was already in progress. It was because our workers were well known and trusted, that we were able to see so many people in such a short time. The amount of sickness we saw was truly appalling. The following sentence was taken from a report of the tour, which Miss Barrett prepared for submission to the Kanarese Committee : 'From the moment Dr. Cutting set foot in any village, until the moment he left, he was besieged with crowds of sick folk, caste and outcaste, Hindus, Christians, Mohammedans, suffering chiefly from malaria, tuberculosis, venereal diseases, and other ailments.' In none of the villages we then visited was there any real medical aid.

The need was obvious and daunting enough. But what was to be our answer? Under God, we believe that the Kowtalam hospital was the answer. That is the short answer, but the road to it was not short. Eight years of planning and working and scheming were to precede the opening of the hospital on the 1st January 1948. The war was in progress, and the road to our goal was beset with every conceivable

kind of difficulty. During the next two years Cyril Firth and I camped repeatedly in the area, looking for a suitable site on which to build, but without success. It was not till 1942 that a leading Brahmin landlord, Desai Bhema Sena Rao, offered to us the piece of land on which the hospital now stands. Looking back over the years we believe that God's hand was indeed guiding us, for we could not have found a site better suited to our purpose. We negotiated for several other sites but negotiations failed, landowners were not prepared to part with their land.

Even after the land had been secured, two more years were to elapse before building operations could begin. A builder had to be found, and building grants from the mission, and from government had to be sanctioned. To build in such an underdeveloped and backward area would have been difficult at any time, but in 1942 India herself was being threatened by the Japanese. To collect materials, and to assemble a small labour force, seemed well nigh impossible. Mr. E. D. Martin, the Indian headmaster of the Wardlaw High School in Bellary, was at the point of retiring from his headmastership, and he was willing to undertake the task of builder. But for his unremitting efforts, and his quite extraordinary skill and resolute determination in overcoming obstacles of every kind, the hospital might never have been built. Stones, timber, bricks, lime, labour, all had to be collected. In order to feed the workers, special rations had to be sanctioned. This involved prolonged negotiations with the 'Collector' of the district. Indeed one of the incentives Mr. Martin was able to offer to his labourers was good food at a time when food was scarce. He provided four kitchens and different cooks to prepare food for the workers of different castes. There is an oldtime Telugu proverb which Mr. Martin used to quote to me, and which deals with the erstwhile manner of dealing with labour problems: 'Beat them on the back, beat them on the back, but never beat them on the belly, or they'll run away.'

HOT SURGERY

First Mr. Martin completed a block of three small private wards, so as to secure the government grant on the whole project. Then he came to live in those wards himself. They were his home for the next two years till the work was finished. He himself checked all the materials as they came in, and supervised every detail of the work. In January 1946 the foundation stone was laid by Major-General Huban, who was then Surgeon-General with the Government of Madras. And exactly two years later, on the 1st January 1948, the hospital was officially opened by the Minister for Public Health of the new Madras State. It had been a long pull, but tremendously worthwhile. No history of the Kowtalam Hospital, however, brief, should fail to pay tribute to Miss Barrett for her part in in the work. People still think of her as the mother of the hospital: and there is no doubt that the whole project grew very largely out of her very real concern for the people of this most needy area.

XX

YOU NEVER HAD IT SO BAD

AT least two considerations made us settle upon the rather dry, dusty, and somewhat dreary village of Kowtalam as the centre for our new little medical venture. Village is a misleading word to describe it, because a place which has a population of more than three thousand is quite a township. But it enjoys, if the word can be used in such a connection, only the amenities—or the lack of amenities—of an Indian village.

First it was, geographically, the focal point of an area in which we had work going on, and in which the Church was growing. The Tungabhadra river, some ten to fifteen miles distant, provides a curving and irregular boundary to the west and north. The Bombay to Madras railway line which crosses the river at one point and then strikes straight southward is the eastern border. At its nearest point to Kowtalam this symbol of civilization is also ten miles away. When the wind is in the right quarter it is sometimes possible to hear the shrill whistle of the engines, or the thunder of the expresses on their way north or south. These serve to remind us that there is a great world of life and commerce somewhere beyond our view. The southern boundary of our area has no line of demarcation at all. Flat unfenced fields of black cotton soil, criss-crossed by the generally dry beds of streams making their way to the Tungabhadra river stretch away to the horizon. Not a house is to be seen as far as the eye can see. There are villages, but these merge into the flat landscape and are invisible, only a clump of trees here and there indicates where a water-course lies, and if there are trees you may be sure a village is also there.

Secondly Kowtalam had a link with the great world—a single, ancient and decrepit motor bus that rocked and rolled and creaked twice daily between Kowtalam and Adoni. Now two or more buses traverse those twenty arid miles in the course of a day. But in 1940 there was but one, and on it we



Kowtalam hospital

set our hope, and to it we pinned our faith. We had it in mind to build only a small hospital, indeed at first we thought only of a dispensary. In such a place the amount and range of medical work that can be done, must be limited, and we wanted to be sure of a line of communication by which we could evacuate the more serious cases, which were beyond our scope, to a district headquarters hospital, or to some place that had larger resources than we were likely to have. That peculiar and long-suffering bus provided that tenuous line of communication.

The main road into Kowtalam has obviously been contrived by nature rather than by the skill of man. Centuries ago, before there was a village, it was a slight depression in the land deepened in the rainy season by the rush of water making its circuitous way to the Tungabhadra river. Today, the art, but hardly the industry, of man has done something to improve it, and to adapt it to the uses of the wheel. The improvement is not always very striking. A boulder in the middle of the road caused a bullock cart to capsize, killing its driver. He was riding in the cart on top of some granite slabs; as the cart turned over the slabs fell on top of him, killing him instantly. Just as the road enters the village it dips sharply, rises again to circumvent the village manure pits and rubbish heaps where pigs grub among the refuse; then it crosses another water-course, before turning sharply to the left into the village, where it comes to a halt under a large tree which serves as the bus terminus. The road which leads from the village to the

hospital is similar to the main road. It, too, started life as a stream-bed, and still serves that purpose after heavy rain, when it carries great volumes of water into the village. But for most of the year it is a road—passable for bullock carts; a jeep can also be driven over it provided the driver is a man of courage and unusual skill. Personally, I am a coward and prefer to get out and walk, or go round by a longer and more circuitous route. The builder of the hospital had the foresight to link the hospital to the main road by a field track which joins the road before it makes its uneven way into the village.

All this talk about bad roads is not really a digression, because lack of communications is a characteristic feature of an 'under-developed' area. Always it spells isolation, and nearly always economic distress. Living in a land where travel is made so easy, it may be difficult for us to understand what this means. Round Kowtalam distances should be measured in hours and not in miles; and even the hours will vary very greatly according to the season. I said to a man who was taking his wife home from hospital, 'I would like to see her again in about a week.' He looked at me for a moment, with a doubtful expression on his face, and replied, 'It is very difficult, even with six bulls we cannot come. In the dry season we can come and go in a day.' Their village was little more than four miles away, but it was the season of the rains, and there were no dependable tracks. The bullock carts must cross fields of black cotton soil. This soil, which is so fertile for growing cotton, once it is wet, makes a clay which constitutes an impassable barrier to any kind of wheeled traffic. It must be seen to be believed. The pastor of the church in Kowtalam once asked me to go with him to the village of Uravakunda where there is a Christian congregation for which he is responsible. It was little more than three miles to Uravakunda across the fields, and I thought it would be a pleasant evening ride on a bicycle. 'I will come along with you after tea,' I said. During the afternoon there was a heavy shower, but after tea the rain had stopped, and it was a warm, sunny evening.

There was no road, but there was a good footpath through the fields. The *mungari*—or early crops—were just showing through the black—actually dark grey—soil. We were no sooner out of the village and in the fields, and had covered barely a quarter of a mile, before we were in real difficulty. The bicycles began to move heavily, and very soon came to a full stop. We descended, and at once our feet began to get stuck too. There seemed to be little we could do about it. We couldn't even wheel the bicycles. The black clay had built up between the tyres and the mudguards, the brakes were firmly jammed, and the wheels would not turn either forwards or backwards. Even our shoes were stuck, and picked up more and more clay with each attempted step. A kindly villager, seeing what had happened to us, came to our aid. He simply picked up the bicycle, perched it precariously on his head, and plodded heavily back to the village. I followed as best I could with my trousers turned up and carrying my shoes.

It was a slightly embarrassing, and mildly amusing, but not at all important incident. Yet mud is not always amusing, and may be a tragedy. One day I removed the eye of a woman which had been destroyed by severe burns. Her face was disfigured by old scars, and parts of her cheekbone and jawbone were visible in her hideously disfigured face. When I asked her husband why they had not brought her to hospital earlier he ruefully replied: 'We did try, but the accident happened four months ago in the rainy season. We actually set out, but the cart got stuck, and we could not get through to Kowtalam.'

In medical practice in England, in general practice as well as in the out-patients departments of hospitals, one of the commonest conditions one meets is 'obesity'—people who are overweight. Our newspapers, and even television programmes, are full of advertisements of nostrums for reducing weight. Thousands of our people are swallowing useless pills in a vain endeavour to get rid of unwanted fat; 'slimming' is their constant preoccupation; at every meal they are concerned not

to eat too much—particularly white bread or potatoes—for fear of getting too fat. In America, apparently, the situation is still worse, and the number of food faddists even greater. Much of this is due to the affluent society, and the fact that 'you never had it so good'. While all this is going on in the West, how very different is the picture in India. How can you measure almost constant hunger? On returning to Britain after a period of years one of the things that strikes one is how well nourished most people appear to be—particularly the children. Even more striking is the impression you get on landing in India after spending a few months in this country; you are struck by the number of people who appear to be undernourished, and again one must say 'particularly the children'. It has been estimated that the average income per head of the population in India is about twenty pounds a year, or a little over a shilling a day, while the average income per head of the population in this country is at least twelve times as much. If the average income is a shilling a day, the income of vast numbers must fall far below that figure. In our welfare state, which is prepared to look after you from birth to death, it is difficult for us to imagine what it is like to live in a state where there is no National Assistance Board and no sort of parish relief. How can we understand and know what such grinding poverty feels like? In cities, and in well-established industries—like the Kolar Gold Fields for instance—where labour is highly organized, people can afford to withhold their labour in an effort to gain for themselves better conditions; and they do. I once heard a manager in the Kolar Gold Fields say that it had been a good year if they had been able to keep their labour force working for two hundred and fifty days out of the three hundred and sixty-five. But in rural India, where there are no trades unions and no labour organizations, where land workers are often bound to their landlords as serfs, men, and women too, cannot easily afford to lose a single day's work. At the last General Election, when our people were being pressed by political agents to go the poll, some of them replied, 'But we should lose a day's *cool*y—give us a day's

cooly, and we will go and vote.' It is no wonder that in Kowtalam not twenty per cent of the people exercised their franchise. They had little idea what the vote meant, but they knew well enough what one rupee meant. Poor Christians will often tell you that they cannot attend church services because it would involve them in the loss of a day's work. Communion services have, on occasion, been arranged to be held at half past five in the morning, so that people might attend Communion before going to their day's work. Hinduism knows nothing of the Jewish law of sabbath observance.

Village houses vary considerably in size, according to the wealth of the owners of the houses; and in construction, according to the building materials locally available. In Kerala, on the west coast, where palm trees abound, the leaves and the boles of these trees are much in evidence in the construction of the houses. Around Kowtalam, as might be expected, the roofs are frequently made of a kind of clay or mud supported on brushwood and matting. Very few village houses can boast any furniture—one or two rough string cots is as much as most people possess. Many times when I have gone into a village house, some member of the family has been hastily dispatched to try to borrow a chair for me to sit on. The less sophisticated villager still thinks that a European cannot sit down without a chair to sit on. Let me try to describe the house of two of my friends. The man and his wife are both employed. He is a teacher in a village school, while she is a full-time paid worker in the church. That should insure that they are by no means the poorest of the poor. But they have six, or by now it may be seven, children—none of them yet old enough to go out to work and to augment the family income. The children alone must provide more than sufficient employment for their harassed mother. Their house is little more than a hut with a thatched roof, and contains only one room. A bamboo wicker-work screen placed across the room divides it into two; but you could hardly describe the two parts as two separate rooms. The screen does, however, provide some

measure of privacy for the parents. Almost the only piece of furniture the house contains is a large string cot—almost the size of a double bed—in which the mother and several of the children can sleep at a time. There may also be one chair, but of this I am not sure. Most likely it would be a sort of canvas deck-chair. There are no shelves for such books as they possess ; no table on which to write ; no cupboard or wardrobe in which to keep any clothes. The family clothes must be kept in one or two small metal trunks, or hung over a bamboo pole which is suspended from the roof horizontally. The bed is in the back half of the house, while a corner of the front half of the house is devoted to cooking. As they are not field-workers, they have no cattle to share the house. There is, of course,



Kowtalam village

no cooking stove, but an open-fire place made of mud is set against one wall. They possess a few brass vessels, which may well have been wedding presents, but poor people do most of their cooking in earthenware cooking-pots. There is a larger pot to store the water needed for all household purposes. Many journeys must be made to the well, which is on the outskirts of the village, that this pot may be filled. Oh for the ease of turning on a tap ! As there is no chimney and no window, the smoke must escape as best it can through the door. Often the atmosphere in the house is blue with smoke. Only small stocks of foodstuffs are kept, and these are stored—the grains in earthenware pots stacked one above the others; the onions, garlic, chillies and a few country vegetables in an open basket; spices, peppercorns, mustard seeds, coriander, cardamoms, root ginger, and so on, for the preparation of curries in small tins and jars. Old tins, old bottles, which in England are consigned to the dustbin are coveted because they are of actual commercial value. When the evening meal has been cooked and eaten, there is little to do but to settle down for the night. This is easily done ; thin mattresses are spread on the floor, and the bedding may consist of no more than a single sheet. Many families do not possess even one woollen blanket. Woollen blankets are seldom necessary. After the sun has set, the house is dark but for the dim light of a small oil lamp. Obviously in such a house there are few facilities for reading or study, and little to encourage a teacher to prepare for his next day's work. If this is a fair picture of the home circumstances of an educated couple who are leaders in the Christian community, what can it be like for the many others who are less privileged, and who have no regular salary at all ?

In the early part of the hot weather, as you walk down from the hospital to the village of Kowtalam, you can see women squatting in the fields scratching the dark sunbaked earth with a piece of coconut shell. What are they doing ? They are trying to glean the few remaining pods of groundnuts (peanuts) which may have eluded the previous harvesting.

Groundnuts—so called because they grow in the ground like potatoes—are a valuable 'money crop'. A 'money crop' is one that is grown for sale, as opposed to 'food crops' which consist largely of grains grown for domestic consumption. Merchants come from Bombay and distant cities to buy our groundnuts, which are converted into margarine and vegetable oils used in cooking. When the crop is ready, the nuts are ploughed up and the bulk of them are collected relatively easily by hand. Then, when the greater part of the harvest has been gathered, women work over the fields again and again. There they squat, hour after hour, in the burning sun, surrounded by a cloud of dust which rises into the air around them, filling their hair and their ears and noses with its fine grey particles. The few remaining nuts which have been gathered with so much effort are collected into a fold in their saris, and carried off to be sold for a few coppers. It is indeed scratching the soil for a mere pittance, which is barely sufficient to hold body and soul together. It is a picture of the destiny of millions in this vast and heavily populated land. As our eyes gaze on this hard, almost cruel, picture, we may well say to ourselves: 'You cannot know what it is like. You never had it so bad.'

XXI

HOT SURGERY

SOME twenty-five years ago I had to travel to Bombay to meet my mother, who was returning to India for a visit. Fourteen years before she and my father had retired from India after a lifetime of service devoted to the country. There can be few people who have lived in India for any length of time, who do not long to visit it again. In the national anthem, Indians sing of their country as their 'motherland'. India is indeed a great-hearted mother, who besides the hundreds of millions of her own children, has adopted countless thousands more who were not born within her borders. These, too, she takes to her warm heart, and binds them to herself with an undying affection.

On the first afternoon of the day on which my mother landed, a garden party was being held in the grounds of Wilson College—the famous Church of Scotland college in Bombay, and we were invited to go to it. There I met a young missionary doctor, who had disembarked that same morning from the ship in which my mother had travelled; and she introduced me to him. He was destined to work in a mission hospital somewhere in central India. He was evidently a keen surgeon, and had recently been elected a Fellow of the Royal College of Surgeons of England. 'It is quite a small hospital,' he told me, 'and hitherto they have not been doing a great deal of surgery there. I am hoping to build up the surgical work there.' Naturally he was bubbling over with enthusiasm, and was full of plans of what he intended to do. I didn't want to damp his ardour, but, to save him from some initial disappointment, I thought it would be kind to give him a gentle word of warning. 'To begin with,' I said, 'you must not be disappointed if you are unable to do all the surgery you would like to do, and that you may think is necessary.' The Indian peasant is a somewhat cautious individual, and a good deal depends upon him, and upon what he thinks, and even more

perhaps, upon what his grandmother thinks. The grandmother, like the mother-in-law, has a great influence in domestic circles. A city dweller pays a good deal of attention to the degrees which a doctor holds, probably too much attention, but a villager may be quite unimpressed by academic qualifications, however imposing they appear to be. He is more likely to wonder, 'What sort of a man is this? How far can he be trusted?' Those questions only experience can answer; and experience demands time. Moreover, where surgery is concerned, your villager is likely to take an extremely conservative view. A minister of religion told me the other day that he had been round to see one of his parishioners who was ill. The lady who opened the door to him appeared a bit surprised to see this man of God upon her doorstep. 'Oh!' she said, 'it is very good of you to call, but really the patient isn't as bad as all that.' The average villager takes a somewhat similar view of surgery. It is something to which a reasonable man would only turn in an extremity—a sort of last resort.

I tried to convey something of this spirit of unreasonable conservatism to the eager young surgeon. Most people in England, and even more people in America, have heard of acute appendicitis, and know that it is commonly regarded as a surgical emergency that requires immediate attention, and in which delay is dangerous. Generally an immediate operation is recommended, and this is carried out as soon as the necessary preparations can be made. But in India, particularly in rural India, appendicitis is a relatively uncommon condition. In the course of many years I have not seen a great many cases — not in the acute phase at least — but they do crop up occasionally. By the time you see a case, the patient has generally been ill for several days; and he may be very ill indeed. Even so I have, from time to time, been confronted with the typical early case in which the man has only been ill for a few hours. In accordance with the teaching given in Western countries one feels bound to press for an immediate operation. But in the East it is generally

wise to proceed slowly and cautiously. It may not be just a coincidence that in colloquial village Telugu 'slowly' and 'cautiously' and 'gently' are often covered by a single word. Hence the oft quoted phrase, translated into pidgin English '... slowly, slowly catchy monkey'. But however gentle one has been, once the idea has been grasped that you are suggesting an immediate operation, you must be prepared for the retort, 'But, Sir! I've only been ill a few hours, and you are saying "operation"'. Let us wait for ten or fifteen days, and if I am not well by that time, we might consider an operation.' Or they may say, 'We cannot agree to an operation till we have consulted our elders'; or, 'We must ask his grandmother first.' If you are sufficiently unwise as to overpress your point, the patient will, as likely as not, insist on going home immediately. The final decision will usually depend upon the confidence which the patient has in the doctor; and confidence is a slow growing plant. In many cases, perhaps in most cases, in adopting a policy of 'wait and see', the acute condition will settle down. With the aid of the anti-biotics and by adopting conservative measures, most cases settle down—at least for the time being. Then, at the end of fifteen days, if the patient has consented to remain in hospital so long, he will remind you, 'Didn't I say that we should wait and see? And you were recommending an operation.' You will then be wise to accept your apparent humiliation, and not try to impress upon him the undoubted fact that he has run a great many unnecessary risks.

These are a few of the pitfalls which beset the path of the eager young surgeon who works in what is euphemistically called an 'under-developed country'.

These considerations may also help to correct the commonly held, but erroneous, view that the greater part of our work in mission hospitals is surgical. It is an undeniable fact that some of the great mission hospitals in India like Miraj, Neyyoor, Vellore or Ludhiana have given a lead in

HOT SURGERY

surgery, as in other fields of medical work; but it would be wrong to suppose that the majority of patients who come to us are in need of surgical treatment. Having sounded this note of warning, we must try to see what it means to do surgery in a rural setting.

If you listen to surgeons talking in England, it will not be long before you hear the term 'cold surgery'. By that they mean an operation which is not urgent, but which is deliberately planned and can be carried out at any time which is mutually convenient for the surgeon and for the patient, and for which he has been carefully prepared. There is not much scope for this kind of surgery in rural India. Almost the last operation I had to do in India was done at two o'clock in the morning on a man with a strangulated hernia. To have left it for a few more hours might have made the difference between life and death. Then he told me that he had had his hernia for thirty years; and that he lived within two miles of the hospital. Such emergencies are, of course, the fruit of fear. But many more are due to accidents, and these are astonishing in their variety. Life in an Indian village, you might think, would be pretty dull and uneventful; but not in a hospital. When you get up any morning, you never know what the day may bring forth.

One day in Kowtalam a mother and father came to hospital carrying with them their small boy. He was about eight years of age. Their village was not more than twelve miles from Kowtalam; but having to come on foot, the journey cannot have taken them less than five hours. They had with them three other children who were weary and utterly scared. In the early morning the small boy had got up to go out of the hut in which the family lived. Just as he emerged from the door, a bullock, which was tethered to the door post tossed up its head—not in fear or irritation, but just in a sort of restless movement—and one of the creature's horns struck the boy in the face which was torn open from his mouth almost to his

ear, a great, ugly, jagged tear. Of course it was quite unexpected, and it took only a moment; the purest accident. The only thing that was fortunate about it was that they lived within twelve miles of the Kowtalam hospital. Naturally the father would have to accompany the boy, and if the father had to go, the mother was not willing to be left at home. Then, what of the other children? So they all came. That is the usual way. The boy's face had to be repaired at once, because the time interval between an injury of this kind and its repair is of the utmost importance. The longer the delay, the greater the danger from infection. The boy's face was carefully stitched, first inside the mouth, then the muscles, and finally the skin. As usually happens in injuries to the face, the wound healed rapidly, and with astonishingly little deformity. Even so, it was nearly a fortnight before the family could go home. During that time they lived on the hospital premises, sleeping on the verandas, cooking their food, picnic fashion, under the trees. This gives you an opportunity of getting to know the whole family pretty well. There was nothing very unusual about the incident; actually 'bullgores', as we call them, are very common indeed, and it would be very easy to devote this whole chapter to them. It is just because accidents of this kind are so common, that this incident was cited; and because it illustrates well the common pattern of life in Kowtalam.

The following incident, thought not unique in its kind, is fortunately much less common. Late one afternoon a small boy was brought to hospital gasping for breath and blue in the face. Yes, even an Indian can look blue in the face. He was obviously in a very serious condition. When I asked what had happened, this was the story I was told. But, first of all a few words of explanation may be necessary. Cotton grows on low bushes, which vary in height between one and three feet. Pale yellow flowers form on the bushes, and in due course, these are replaced by pods. When the pods are ripe they burst, and white tufts, resembling ordinary cotton wool, are

exposed. Generally the crop is harvested in the early part of the hot season, but, if the crop is very good, the fields may look as though they had been caught in a snowstorm. The harvest is gathered by picking off the tufts of cotton wool by hand; and the work is generally done by women. Often the women are not paid for their labour in money, but are allowed to retain a proportion, albeit a very small proportion, of the cotton they have picked. Later they may either sell their cotton to merchants; or some of the shopkeepers will accept it in exchange for grain or other goods. It is in effect a primitive process of direct barter.

The small boy in this story had found a heap of cotton pods in his house, and knowing that it was negotiable, had taken a handful of it round to a small shop and had exchanged it for some puffed rice. He was enjoying the puffed rice, when his mother caught him. She realized what had been going on, and, without thinking, hit him a resounding whack on the back. The boy gave a sharp gasp, and one or two grains of the puffed rice, which were in his mouth, slipped down into his larynx or windpipe. The boy choked; the rice grains were



Bringing home the cotton

caught; and he could hardly breathe. Here was a situation which required immediate action : only an operation could save his life. With a minimum of preparation the operation was done; the windpipe was opened, the offending grains removed; and a small silver tube tied in his throat so that he could breathe again. Quickly he recovered, and within ten days was ready to go home. What appeared to be a trivial accident might well have ended fatally.

On a rainy afternoon in August a young man of twenty was lifted down from a bus, and laid on the veranda of the Kowtalam hospital. He was an itinerant barber who sometimes conducted his business on the platforms of railway stations, and sometimes in the compartments of trains. Railway journeys in India, which may go on for several days together, tend to become tedious, and a few minutes at least may be salvaged from the time lost by having a haircut while in transit. Moreover for the barber to drop off at small stations along the route may serve the double purpose of doing a little business, and also avoiding ticket inspectors, if he has not been too particular about paying his fare. If a ticket inspector should be so inconsiderate as to put you off the train because you had overlooked the formality of buying a ticket, there is always the chance that you may do better on the next train — more especially if it should happen to be a night train. I should not digress, but for any who may, sometime, want to travel on an Indian train when short of money, a further word of advice may prove valuable : the most favourable moment to mount a train is just as it is moving out of the platform.

Nine miles from Kowtalam is the small wayside station of Kupgal. Express trains do not stop there. The perambulant hairdresser, about whom we are writing, was trying to get into a train when it was already moving at a considerable speed. Whether he really did have a ticket or not I never knew. In one hand he carried the appurtenances of his profession, which included numerous bottles of lotion. The compartment he was

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trying to enter, as is usual in Indian trains, was already full, and he was having some trouble with the door. One of his bottles slipped out of its carrier. He tried to save it, but, in so doing, lost his grip with the other hand, the one with which he was holding on to the train. He fell between the moving train and the platform. A wheel of the train passed over one arm and hand. They were not completely severed, but were so crushed as to be almost unrecognizable. The train proceeded on its way, the driver and the guard being quite unaware of what had happened. Some people who were standing on the platform picked the boy up and lifted him on to the platform. He belonged to some place in north India — a thousand miles away, and he had no friends or relations close at hand. He spoke only Hindi, the national language, which is more foreign to most of our people than English, so it was not easy for any of the people there to communicate with him. Later in the day, when a bus going to Kowtalam passed that way, the boy was lifted into it, and the driver, in due course, deposited him on our hospital veranda. There was, of course, no hope of saving the arm. A high amputation, close to the shoulder, was the best that could be done ; and even that could not be long delayed. In fact it was done as soon as the things could be got ready. That is what might be called 'hot surgery'. Strangely enough the wound healed by first intention. It could hardly have done better had it been 'cold surgery', and the operation carefully planned beforehand. We had to do everything for the boy. It was probably his first, and perhaps his only contact with Christians ; but he did not immediately forget us. Some months later, when his journeyings brought him our way, it was Christmas time, and he dropped in to spend Christmas with us ; and shared in our hospital nativity play.

These selected sketches are no more than a shadow of the grim reality ; and barely indicate the family tragedies which so often lie behind the events that bring patients to hospital. If your experience of hospitals is confined to hospitals in Britain, with their ample equipment, and their teams of consultants

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and specialists—physicians, surgeons, anaesthetists, radiologists, neurologists, obstetricians, pathologists, nurses and innumerable other ancillary services, it would be difficult for you to imagine what it is like to work in a small country hospital like Kowtalam, where there is generally only one doctor and no proper provision for his holidays, or for possible sickness. It is little use his asking : 'Which is my weekend or my day off ?' For him such things hardly exist. The senior male nurse, Raju, to whom reference has already been made in these pages, was both nursing superintendent and dispenser. We had two other male nurses, who, fortunately for us, were both married to trained nurses ; which gave us a possible nursing strength of four. Besides these we had a laboratory technician, Ratnappa, and a senior but extremely reliable midwife, Sonabai ; but no other trained staff. These eight, together with three others who were responsible for cleaning, carrying stretchers, and doing the small repairs that always seem to be required in a hospital, made up the entire establishment.

In December 1956 a small petrol motor and electrical generator were installed to provide current for a new X-ray set, and for lighting the operation room. But up to that time the hospital had to depend entirely on paraffin lamps and oil stoves for lighting and heating. Domestic heating, apart from cooking, fortunately is never necessary. Sterilization of all instruments, dressings and linen required for surgical purposes, all had to be done on oil stoves. To begin with we possessed very few instruments, and improvisations were constantly having to be made; indeed our entire furnishings and equipment could hardly have been more meagre. On occasion I have had to send over to my wife for the loan of a few domestic spoons of various sizes when we were experiencing unusual difficulty in closing an abdomen. We have even had to approach the village silver-smith for the loan of a few of his tools. The most humble tool, when well boiled, may prove to be a most serviceable instrument in an emergency.

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Try to picture for a moment what it means to do surgery in such circumstances. Whenever an important operation has to be done, whether by day or by night, the whole hospital staff must be on duty together. That was why, whenever possible, operations were postponed till the afternoon—and often the late afternoon at that—after the routine work of the hospital was finished. Our senior nurse-dispenser served as anaesthetist, and was responsible for looking after the patient. One nurse must assist the doctor with the operation, a second must be in charge of the instruments and sutures, while the third presides over the primus stoves and the sterilizers. Sonabai, the veteran midwife, was always on hand to hold basins, or to fetch and carry as necessity might arise. Lighting was always a difficulty. A petromax lamp, when in good working order, affords a good deal of light, but it is never easy to decide on the best position for it. Besides light, it always emits a good deal of heat, and not an inconsiderable amount of noise. When it is balanced somewhere above and behind the surgeon's left shoulder, another assistant, not necessarily a very highly skilled one—is required to mop the perspiration off the surgeon. This is indeed 'hot surgery'. An electric torch can be most serviceable in illuminating the inner recesses of the human body, but it is not always easy to hold it still so that the light does not disappear at the moment when it is most needed ; nor is it easy for the torch bearer to shine the light in the right place, and at the same time keep himself out of the way. There is often some competition between him and the surgeon as to who gets the best view.

If an operation has to be done at night 'it's just too bad' as they say ; because, even if the staff has been on duty half the night, they must be on duty again in the morning, for it is another day, and there is no other staff. And after an operation has been done, who is to look after the patient during the night ? Think of the small boy, for instance, with the silver tube tied in his windpipe. Somebody must be there during the night to see that it doesn't get blocked ; and to do something

about it if it does. The three male nurses, which includes the nursing superintendent, took it in turns to be 'on call' during the night ; and the relatives of the patients usually did the calling. However many times the 'duty nurse' might be called during the night, he seldom failed to appear at hospital staff prayers the following morning.

In larger hospitals, like Chikballapur, it was possible to provide for at least a skeleton night staff, and a separate staff for the operation theatre, and this made things a good deal easier ; but such provision was not possible in a small hospital like Kowtalam. Because of its very situation, it was constantly being called upon to carry responsibilities which were far beyond its original intention, and to attempt to do work for which it was neither designed nor equipped. Were it not for the readiness of the staff to work together in the most trying circumstances, and to lend each other a hand whenever it might be needed, and without standing upon their dignity or studying their personal convenience, the work could not be done. But whenever the staff of a Christian hospital does live in this way, it becomes a true Christian religious community ; and it is only in such a community that the spirit of its Lord is made manifest, and Jesus Christ is set forth.

XXII

YESU PRASADA

THE first bus into Bangalore from Chikballapur used to leave Chikballapur at seven in the morning. It is an interesting road into Bangalore, at least my wife and I always thought so, and we must have travelled over it hundreds of times. About one and a half miles from Chikballapur, on the right-hand side of the road, you come to a fairly large *tope* of mango trees. The word *tope* is pronounced like 'hope'; and it means a clump, or grove, or plantation of trees—usually fruit trees. Set among the trees is a small wayside temple, sacred to the monkey god Hanuman; in our part of the country he is more commonly referred to as Angenaya Swami. The setting of the temple could hardly be more appropriate, as the *tope* and also the great banyan trees which line a good deal of the road into Bangalore, swarm with monkeys. As the first morning bus approaches the temple, it slows down, and finally comes to a stop exactly in front of it.

The temple priest is always ready and waiting by the roadside; and as the bus pulls up, he runs out with his little brass tray on which are set out some burning camphor, a few flowers, some little heaps of red and saffron-coloured powder, and usually some odd coins of small denomination. The priest first approaches the bus driver, who makes his *puja*. He puts his hands together in an attitude of prayer, touches the brass tray with both hands, picks up a flower off the tray which he puts behind his ear, and dips the tip of the middle finger of his right hand into one of the heaps of coloured powder and then applies the powder to the middle of his forehead. He may murmur one of the many names of God as he goes through this simple ceremony. The *puja* is over. God has been acknowledged, and his protection and his blessing on the day's duties have been invoked. The priest then proceeds to the back of the bus, gets in, and moves up one side and down the other. He stops in front of each passenger and proffers his tray. Most



Village gods

of the passengers will follow the example of the driver, touch the edge of the tray, accept a flower, and, perhaps, add a coin to the collection on the tray. If the passenger is a Moslem, he will usually look straight in front of him, and disregard the tray; if he is a more sophisticated individual, he may appear to be absorbed in his paper and pay no attention to the priest. We usually just smile at the priest as he offers his tray. There is no suspicion of superiority or patronage in the smile—just a quiet acknowledgement of his courtesy in inviting us to share in the worship. The priest is satisfied and moves on. The whole ceremony occupies only two or three minutes; and few of the passengers seem to regard this daily rite as inappropriate or a waste of time.

It is difficult to imagine anything like it happening in contemporary England. We have too many buses, and we are in too much of a hurry. India is essentially a religious country, and people do not think of religion as something that is weak or sentimental, or out of touch with the hard facts of life—and goodness knows the facts of life are hard enough in India. Nor is religion something of which you need to be ashamed, and for which you need to apologize. In spite of growing materialism, and in spite of the fact that its Constitution roundly declares that it is a secular state, India still remains a religious country. Religion is such a universal and dominant feature of the Indian scene, that in this last sketch we shall linger to look at a number of pictures drawn from daily life and actual experience which illustrate this essential fact.

When you have spent twenty-eight of the best years of your life in one place, your last day there is likely to be a memorable one. Our last night in Chikballapur was hot, and we spent only a few of its sleepless hours tossing about on the bed. The house was in almost complete confusion; the accumulation of years, which had not already been thrown out, was still lying about everywhere. Innumerable articles of baggage in varying degrees of readiness for travel were scat-

tered round the rooms and the verandas of the old mission bungalow. In the grey light which precedes the sunrise, the hospital nurses assembled below our bedroom window to sing familiar and well-loved tunes. It was the beginning of the end. Still clad in night attire we joined them to share in the singing.

Soon after the nurses had gone another group of early visitors was on the doorstep. They came from the neighbouring village of Wapsandra. One of our friends from that village was particularly anxious that we should come and visit the new house which he was building, and which was nearing completion. The date of its ceremonial opening had been fixed, and he was disappointed that we were leaving Chikballapur before that important event took place. The *gruha pravesham*, or ceremonial 'house-opening' of a new house, is an event of the utmost importance, and can on no account be dispensed with. We said we would go there soon after eight o'clock, but even so, a number of his relations and friends had already assembled in front of the house before we got there. After the greetings and garlandings and presentations, a group photograph had been arranged. That photo is before me as I write, and I see that there were more than thirty people in the gathering, including women and children. My friend was a merchant, and a cultivator of potatoes and onions. His new house was not a very large one, but it was of very contemporary design, and unlike any other house in the village. Anyone of us would be glad to live in such a house, although it was planned to suit an Indian rather than an English way of life. Our friend showed us round the house with justifiable pride. The kitchen, store-room and bathroom were separated from the rest of the house by a small passageway. In the floor of the dining-room was a sort of square manhole which gave access to a large underground, concrete lined cistern or cellar for the storage of grain. This is a fairly common feature of village houses. When the *ragi* harvest has been gathered, it is quite usual to store a year's supply of grain in a sort of rat-proof cellar under the

house. Then he showed us a small room, whose walls were lined with polished white plaster. 'You see this room,' he said, 'the walls and ceiling are perfectly white. This room is for prayer and meditation only. I intend to spend at least one hour here every morning.'

He was, as I have said, a farmer and merchant; I had known him and his family for many years, and I knew that he was not an exceptionally religious sort of person. What he was saying to me did not surprise me as much as you might suppose, because many, probably most, Indians set apart some part of their house for the worship of God. A Brahmin friend, because he had no other space in his house, constructed a small shrine in his kitchen; another installed the household deity in a wall cupboard which has a glass door, and he keeps a light burning constantly before the image. What would surprise me very greatly would be if any of my English friends in building themselves a new bungalow had planned for one room to be set apart exclusively for the worship of God. The fact that we believe that God may be worshipped anywhere, does not mean that we need not set apart a special time and place. These things help us to remember.

But religious observance among Hindus is not confined to contemplation and meditation. Some years ago a man came to see me in the bungalow. He came from a small town some thirteen miles from Chikballapur where he and his brother kept two shops, one a cloth shop, and the other a general store where they sold food grains and other household commodities. But his chief delight was his garden. I suspect that he devoted many more hours to his garden than to his business. It was what we should probably call a market garden, because he grew vegetables rather than flowers, though he always had a few flowers as well. For the most part the flowers had to look after themselves, and tended to grow wild. Even so they were of great value to the bees which he also kept. At one time he used to grow some bananas of the more exotic varieties,



Coconut palms

but in recent years he has given those up. There were a number of coconut palms scattered about his garden, so that whenever we went to see him, he gave us coconut water to drink. Most important of all was his vineyard. This covered a considerable part of his land, and he tended it with the greatest care. He had not had a great deal of formal education, but he was very fond of reading, which, as I have already mentioned, is unusual among Indians. He could read English freely, and often came round to our house to borrow books. The English classical novels particularly seemed to interest him. Gradually a close friendship developed between us, and it was always a pleasure to drop in and see him in his garden.

On the particular occasion about which I am writing, after a little general conversation he produced from his pocket two hundred rupees in five rupees notes. That would be worth about fifteen pounds, and it was in the days when one pound sterling was still a considerable amount of money. He handed me the notes and said nothing ; so after a few moments I asked him, 'What is this for?' 'It is for the hospital,' he replied. 'Yes,' I continued, 'but why are you giving it to the hospital?' I knew that he was not a very wealthy man. Then, quite simply, and without the least self-consciousness he said, 'God told me to give it to you ; so I have brought it along.' It was as simple as that. I knew, of course, that he was a devout and very orthodox man, and that he belonged to what is now a very exclusive caste, but his words amazed me, and they reminded me of the words Jesus once spoke about a Roman soldier 'Verily. . . I have not found so great faith, no, not in Israel'.

In less theological terms, what had happened was something like this. He had had an exceptionally good crop of grapes that season, and he had been able to get a very good price for them. While he rejoiced in his unexpected good fortune, he realized it was not sufficient just to rejoice, he must share part of his gain with others, and this was the way

he chose of doing it. Quite recently he acquired some additional land adjoining his garden, and to irrigate it he dug a new well and installed an electric pump and constructed a stone water tank. Quite naturally it occurred to him that he should share the water. In his town there was no municipal water supply, so he led a pipe from his water tank to the side of the road which passes his garden, and he put a tap there and constructed a drinking trough for cattle, so that anyone who passed by, and animals as well, might drink.

Let us consider another example of piety, and this time let it be from Islam. One of the most faithful servants our hospital ever had was a Mohammedan—Mohamed Peeru Sahib by name. He worked in our hospital from the day it was opened in 1913 until his death nearly forty years later. He was the hospital *peon*. That is to say, he was a sort of messenger. He opened the doors in the morning and closed them at the end of the day. It was his job to attend upon the doctor who worked in the out-patients department, regulating the flow of traffic; bringing the patients in to the doctor; and directing them where to go after they had seen the doctor. As a result of standing by the doctor for so many years, he had developed a very considerable clinical acumen. He not only brought the patient in to you, he would also tell you what was the matter with him. As he had been brought up under Dr. Campbell, eye diseases were his speciality. 'It's just a pterygium,' he would murmur, as he brought the patient in. The job of a *peon* is usually regarded as rather a humble office, but in a law court or a government office it may be a much coveted position—it is like being a commissionaire on the steps of the Grand Hotel. Sometimes there are casual emoluments attached to the post. Because photography was Peer Sahib's special hobby, he always regarded the X-ray department as part of his responsibility. He was in fact quite capable of taking X-ray photographs and developing them.

Among many other odd jobs which he had to do, he had to take money to the bank or bring money from the bank.

Always he was a very poor man, and it would be no exaggeration to say that he was never out of debt—except once, and that was very temporarily. Through the years, many thousands of rupees of hospital money passed through his hands, and he guarded them more closely than ever he did his own money, and very seldom a rupee went astray. Apart from his camera, he owned only one piece of property, and that was a house which he had built with much difficulty and in the face of a good deal of opposition from his superiors. When it was built he was not able to live in it for long, because he had to let it, as he needed the rent to hold his numerous creditors at bay.

Peer Sahib was getting old, and was afraid he might not live much longer; but still he had not been able to fulfil one of the most important obligations laid upon every devout Moslem. He had not been able to make the *hadj* — the sacred pilgrimage to Mecca. To make the *hadj* became his one consuming passion. In 1940, despite the fact that the Second World War was then in progress, he was able to fulfil this one dearly cherished ambition, but it cost him everything he had. It was his 'pearl of great price'. He sold his house, which he had built with such loving concern, and which was his sole possession. He got two thousand four hundred rupees for the house, and thirteen hundred of these went to pay off his outstanding debts in the town. One of the conditions attached to making the holy pilgrimage, he told me, was that the pilgrim must be free from all personal debts. This was the only time in his life, that I can think of, when he was free of debt. Seven hundred rupees bought him a return ticket as a deck passenger in a pilgrim ship between Bombay and Jiddah; and the remaining four hundred was held in reserve to meet incidental expenses. When he got back to Bombay he was again out of funds, and sent me a telegram asking me to wire him some money to Bombay to enable him to get home.

Just before he left Chikballapur, I asked him if he would take his camera with him, to bring back some photographs to

remind him of this supreme event of his life. I had said the wrong thing. I think the old man was deeply shocked by such an improper suggestion. 'No,' he said 'I must keep my mind fixed upon God (Allah), and pray every yard of the way.' Those were his actual words, and I am not likely ever to forget them. While he was in Mecca he fell ill; and he told me afterwards that he had hoped that he might die there. That would have been bliss indeed. But it was not to be; and ten years later he had a stroke and died in the hospital he had loved and served so well. We carried him out of Chikballapur to the Moslem burying ground, and laid him to rest on his right side, under a great banyan tree, wrapped in a red cloth, and facing towards Mecca. If there were only a few Moslems as devout as Peer Sahib, we need not be surprised that Islam is spreading so fast in Africa and in other parts of the world.

One further incident may be cited, because it throws yet a different light — perhaps I should say light from a different angle, a more peculiarly Christian angle—upon India's freedom from reserve where religion is concerned. My wife and I were travelling from Chikballapur to Kowtalam by train. We were on almost the last stage of the journey. It was late evening, and it was already dark, as the Bombay Express pounded over the flat stretch of country between Guntakal junction and Adoni. I was absorbed in, or more likely drowsing over, a book, when I became aware of a somewhat heated discussion that was in progress between two men at the other end of the carriage. Indian railway carriages, especially the 'inter-class' carriages on the so called 'broad-gauge' lines, are a good deal longer than compartments on British Railways, so one may be some distance away from people at the other end of the carriage. One of the men was a Christian, who had wife and child travelling with him. He came from a small country town in Cuddapah district where the London Mission has been working for many years, but he was not a mission agent of any kind. He was, in fact, a clerk in the civil branch of the Indian Air Force, and was returning to his station in north India—a

place nearly fifteen hundred miles away from his native village. The other man was a Hindu, an officer of the State Bank of India, who was going to join the branch of his bank in Adoni.

What attracted my attention was that they were discussing salvation. They had evidently been talking about contemporary events in India, and in the world in general, and were fully agreed that the world appeared to be in a bit of a mess. More particularly they were concerned about the rising costs of living, and the widespread corruption in their own country. The Air Force man was contending that the confusion and the unrest in the world, and in India, were due to evil in man, in fact, to sin in men's hearts. Because of this sin, man was unable to save himself, and stood in need of a saviour. God had provided such a saviour in Jesus Christ. It was for man to accept God's gift. The banker could not accept this at all. He did not believe that he was bad or a sinner; in fact, he didn't believe himself to be in need of a saviour. He believed that all that was needed was that men should be good, and learn to live together and to help each other. 'But,' objected the airman, 'that is where man fails, that is exactly what he cannot do.' The banker remained unsatisfied. 'If man is essentially evil,' he replied, 'it must be God's fault for having created him so. In any case I do not believe in such a God.' Most men would agree with the banker's objection; and we, who are Christians, would also agree with him in not believing in such a God. Perhaps it is just because we cannot, and do not, believe in such a God that we recognize ourselves as sinners.

The train arrived at Adoni before the argument was concluded, and the banker descended from the train, and we descended with him. Considering the utterly diverse points of view of the two men, it was hardly to be expected that agreement would be reached; but the Christian clerk bore his testimony fearlessly and fairly, and before a complete stranger. It would seem that no time or place need be inappropriate for the discussion of theology. But one more word must be added

to balance the picture. One cannot listen to people talking for very long in bus or train, and in the first class or in the third, before you hear that they are talking about money—and talking about it much more freely than would generally be considered polite in this country. Money is an almost universal pre-occupation in India, even more than in this nation of proverbial shopkeepers.

These sketches, drawn from daily life in India, show something of the scene in which our task as Christian missionaries is set—the task of making Christian known. In such a setting, how is it to be done? In what language must we speak? Surely the most telling language is the language of conduct and action. That language is not easier to learn or to speak than the language of words.

In front of the hospital in Chikballapur is a spacious entrance hall—a hall which serves as a waiting-room for patients. On three sides of it are open arches which support the roof. Above the central arch in front, in large English lettering is the name of Wardlaw Thompson, the great missionary statesman in whose memory the hospital was built; and above that in Kanarese letters, are two words: YESU PRASADA. Richard Hickling who conceived the hospital and built it, chose these words for its motto. He used to translate them into English as 'The Gracious Gift of Jesus'. *Prasada* is not the word which is ordinarily used for a gift or a present. It is a Sanskrit word, and is taken from what we might call the liturgy of Hindi temple worship. The worshipper hands his offering to the temple priest, who, in turn, presents it before the image. Part of it is then returned to the devotee, and this is called the *prasada*. It signifies the blessing or gift which the god bestows upon the worshipper. It was that which Hickling had in mind when he chose the words; and he could hardly have chosen words which were more appropriate. It was his hope that the hospital might be 'the gracious gift of Jesus', the gift which Jesus bestows. Jesus brought healing

to the broken bodies of men, because He knew it to be His Father's will. 'We must work the works of Him that sent me, while it is day,' He said, and immediately turned to the man who had been born blind, and healed him. What He did was the will of the Father, and in doing it the heart of the Father was revealed. Action of this sort speaks louder than words, and more clearly than words; and it speaks a language which all men who are in need can understand. It knows no barriers of speech, or race, or nation, or class; it speaks to men where they are. Rich and poor, high caste and low caste, cultured and illiterate, hear it and understand.

'He that believeth on me, the works that I do shall he do also; and greater works than these shall he do.' Those too were the words of Jesus. Can they be true? Is it conceivable? William Temple commenting upon them, says, 'In scale, if not in quality, the works of Christ wrought through his disciples are greater than those wrought by him in his earthly ministry. It is a greater thing to have founded hospitals all over Europe, and in parts of Asia and Africa, than to have healed some scores or some hundreds of sick folk in Palestine His works are no longer limited to Palestine, but are diffused over the world.'

'As all rivers run to the sea; so all religions are essentially one,' say many of the politicians and some of the national leaders of India. 'By their fruits ye shall know them,' said Jesus. Judged by that standard, all religions are manifestly not one. India, as we have endeavoured to show, is a religious country—far more religious than Britain—and many different religions are to be found within its borders, but none of them have yet given to the country hospitals that are to be compared with the Christian hospital. The Christian hospitals are in a peculiar way 'the Gracious Gift of Jesus'. But Jesus brings to men more than the healing of broken bodies. He gives Himself. He is himself both the gift and the giver. The gift we have received we seek to share.

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O God, whose grace has appeared for the salvation of men, we beseech thy blessing upon the whole Church of Christ, which thou hast called to be the means of thy grace; and so prosper its witness and labours that this world of men may receive thy saving grace, and find through Christ its redemption.



POSTSCRIPT

Chikballapur and the C. S. I. Hospital have seen many changes since this book was first printed. The hospital which was formerly on the northern boundary of the town surrounded by green fields, is now surrounded by buildings varying from small mud and brick rooms jammed against the west wall of the hospital compound to a large bus garage for the Govt. buses which ply from Chikballapur all over the area. These buses carry most of the patients who come to the hospital now, although the bullock carts are still there. The demands of the patients are today more sophisticated too and "specialists" are required in the medical staff. We now have a gynaecologist/obstetrician, E. N. T. and Eye Surgeon and an orthopaedic Surgeon, all of whom require time in the operating theatre as well as various specialised facilities there. The old operating theatre needs repair but in any case is inadequate and a new operating theatre suite is required with all the facilities necessary for the complex operations possible today. Supporting facilities in the wards will also be required to give the patients the intensive care they need. We hope that the nurses from the Sister Morch School of Nursing will be able to give that care after their training in our School re-opened in 1984. With its new buildings completed in 1988, the School is able to cater for 10 students each year in the new condensed course of 3 years, introduced from 1987 by the Indian Nursing Council.

The hospital today has over 160 beds, filled with a wide variety of patients, giving good experience to the student nurses, and junior doctors who work there. Their training is also enriched by the developing work in the village community centres and rural dispensaries. A well equipped hospital is essential for the base but the needy patients are in the villages and the Yesu Prasada must be shared with them — many with tuberculosis, leprosy, anaemia and a host of other diseases. Now treatment that can cure is available for these conditions but the gap between the cure and the patient who needs it remains, and it is one of the tasks of C.S.I. Hospital, Chikballapur to help bridge that gap today.

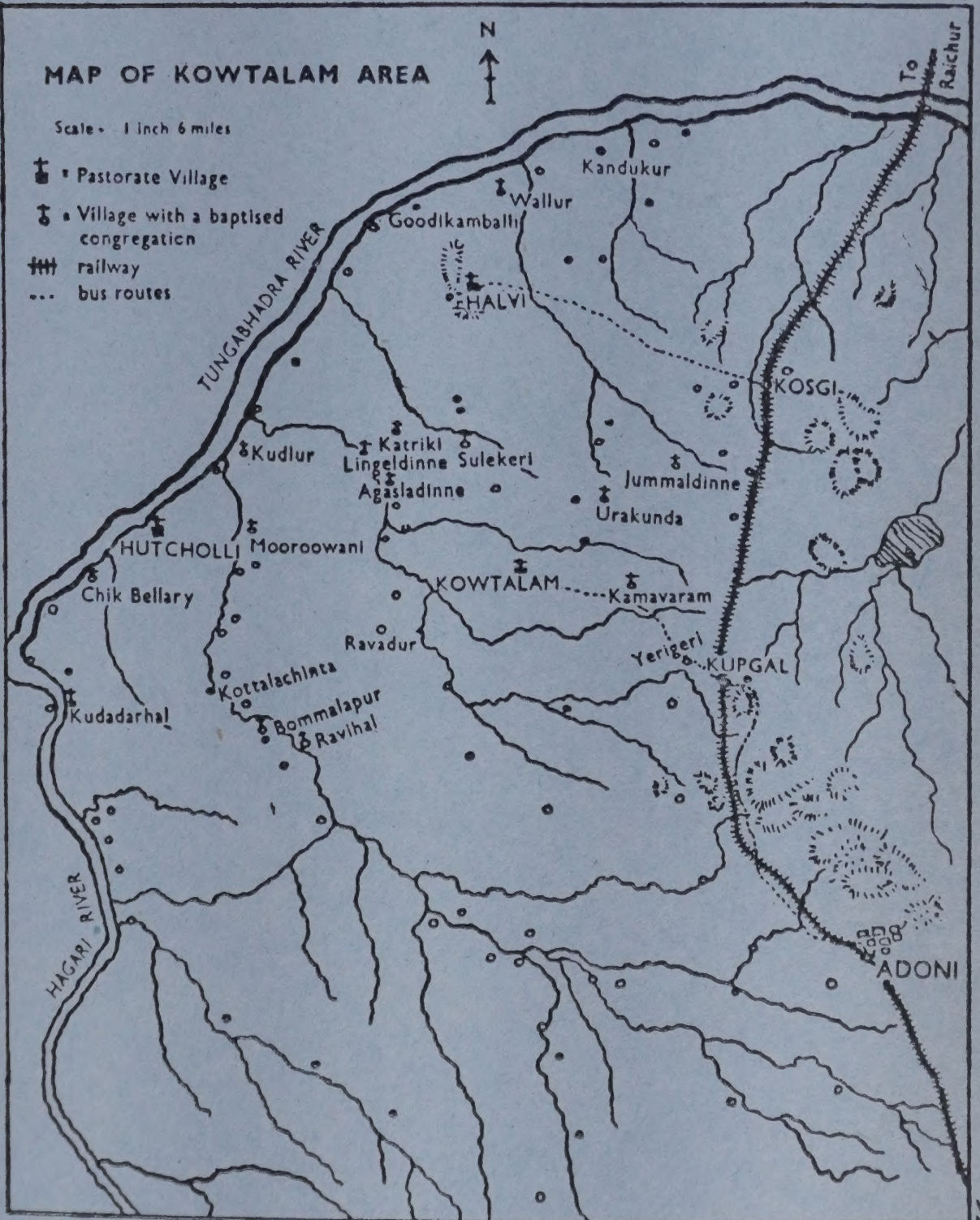
Dr. R. L. Robinson
Medical Superintendent.

BOMBAY

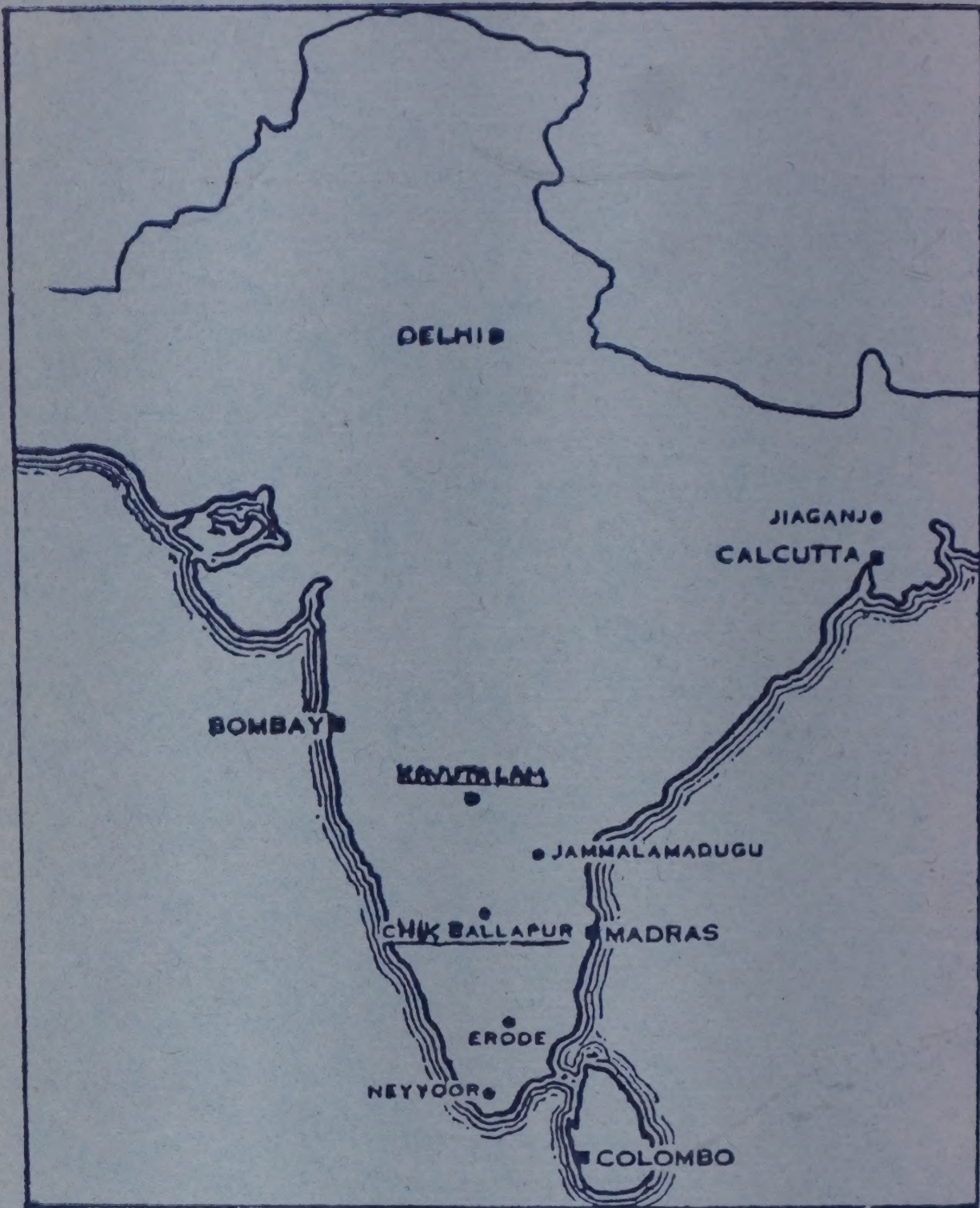
MAP OF KOWTALAM AREA

Scale - 1 inch 6 miles

- ✚ Pastorate Village
- ✚ Village with a baptised congregation
- ≡≡≡ railway
- ... bus routes



MADRAS



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